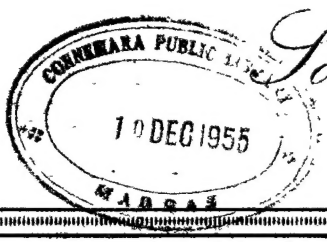
The Clinical Association

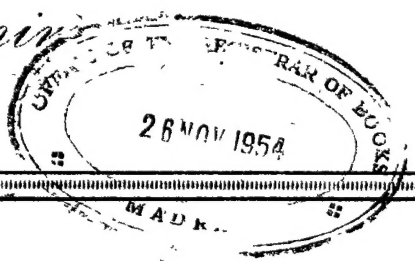
OF THE

GOVERNMENT HEADQUARTERS HOSPITAL, COIMBATORE



Souvenir

1953



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The Clinical Association

OF THE

GOVERNMENT HEADQUARTERS HOSPITAL, COIMBATORE

Souvenir

1953

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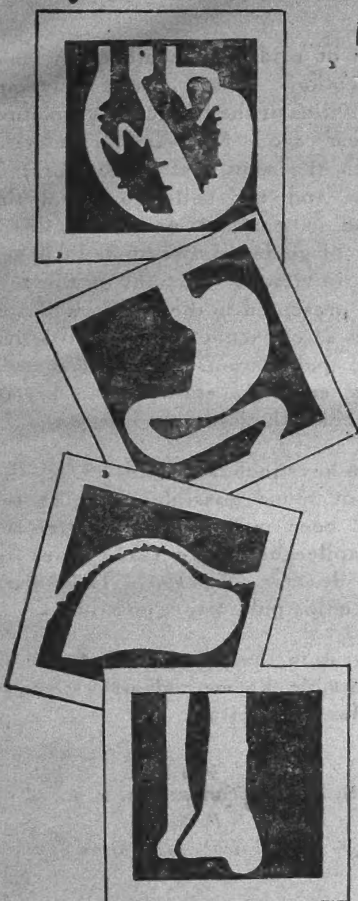
Organic Substitution & Protective Therapy with Specific Action



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FOREWORD TO THE FIRST SOUVENIR

It is with genuine pardonable sense of pride and achievement that I write this foreword to this modest publication. This is just a Souvenir, a memento or a thing to remember by the activities of the Clinical Association of this hospital started a little over a year ago. My Annual Address reproduced on the next page has set forth the aims and objects of this Association. It was felt desirable by me and my colleagues that the proceedings of the Association should find in part, if not in whole, a permanent record in order that it may be of guidance and some little use to men that may follow us. With this object in view, an account of the few of the more important and interesting cases presented in the meetings during the year is published in these pages. Besides 21 of such cases, 4 instructive articles contributed by members also find publication. The Secretary's report for the calendar year 1951 and an appendix showing the list of meetings and the cases presented therein conclude the issue.

Though it would have been better to have included notes of all the cases presented during the year, it was not found possible to do so for several reasons and a small beginning has been made. It is a matter for gratification that quite a number of my colleagues have taken pains to prepare and submit notes of cases. They deserve all praise. Thanks are due to all those that have taken pains to make this publication possible.

No more claim is made for this publication than the modest one of an honest attempt to improve to the extent possible the methods of systematic examination and clinical diagnosis in our mufassal hospitals.

Govt. Headquarters Hospital,
COIMBATORE,
20—3—1952.

S. Balasubramaniam, M. B., M S,
President,
Clinical Association.

FOREWORD TO THIS SOUVENIR

It is indeed a pleasure to publish this, the third Souvenir of the Clinical Association, with my ample apology though, for the belated publication. For various reasons, partly beyond our control, the Souvenir could not be brought out earlier. Every effort has been made to retain its standard and get-up. Of the 151 cases demonstrated at the Meetings of the Association in 1953, it has been possible to include only 23 cases. Where necessary, some comments have been offered. Two special articles also find publication. Of course, the President's Address and the Secretary's Report to the 3rd Annual Meeting of the Association held in 1953 as well as the "Hospital Notes" are all there. The list of meetings held in 1953 with the details of cases demonstrated and the list of doctors attached to the Hospital form the Appendices to the Souvenir.

Thanks are due to all my colleagues who have taken pains to prepare and submit notes of cases and articles and made the publication of the Souvenir possible.

Govt. Headquarters Hospital,
COIMBATORE,
1—11—1954.

S. Balasubramaniam, M. B., M. S.,
President,
Clinical Association.

PRESIDENT'S OPENING ADDRESS

TO THE

3rd ANNUAL MEETING OF THE CLINICAL ASSOCIATION

ON 23rd JANUARY 1954

Friends,

I did not expect to be able to be present amidst you at this, the third Annual Meeting of the Clinical Association. But, if for no other reason than this opportunity and pleasure of partaking in this function, I am indeed happy that I am continuing in this place.

The purpose and importance of this Association have been repeatedly stressed by me in my previous Addresses. It will bear repetition to say that the main purpose is to develop a scientific outlook and approach to your daily problems in the wards of this Hospital. All of us are ready to condemn quackery but it is not adequately recognised that if a qualified person of scientific medicine deviates from scientific methods he is no more than a quack, in fact, worse. A straight-forward quack can be recognised as such, but a qualified one is like a thief in Sanyasin's saffron robes! So this Association would have achieved its purpose only to the extent that it inculcates and fosters a scientific approach amongst us in dealing with our day to day professional work. Advertisement and sale of patent medicine with loud and spurious claims in such large quantities often encouraged by qualified men is a measure of ignorance and superstition of our patients. I would recommend to you to study Shaw's play "Doctor's Dilemma" and profit by its satire on the evils in our medical and surgical practice.

This Association has done well but we should not allow ourselves to stagnate in a spirit of complacency. A selective systematic study is absolutely essential if we are to be reasonably competent and keep ourselves abreast of knowledge. No refresher course can ever be a substitute for this selective reading. By this I mean that we should at least refer to the relevant portions in our books in relation to any difficult case seen during the day, as time won't permit us to read from cover to cover of any book. If we do so and if we keep within reason (that is to say, employ the scientific approach) in our diagnostic problems we are bound to raise and improve our standards beyond all recognition. This will be the surest way to kill quackery and not by any legalistic approach.

As an enlargement of our activities I would suggest that some of our young men in this Hospital may do clinical research on subjects like anæmias, nephritis, heart diseases, intestinal obstruction, peptic ulcers etc. A large number of these cases are admitted into this Hospital every year and I am sure a systematic study of them will bring to light additional valuable information on these conditions. Another suggestion that I would make is that we may organise and conduct a Rural Medical Service in this coming year. There is no duress on any one; those of us who voluntarily desire to render such service can partake in this work. We should be willing to render this kind of service with pleasure in our villages which do not have the elementary medical facilities. I am sure all of us will co-operate in this work.

You have during the last year unstintingly co-operated with me in the conduct of this Association. While thanking you heartily for it I request you to strengthen this Association more and more, improve it in all possible ways and make it a model for other hospitals to copy.

Coimbatore,
23rd January, 1954

Dr. S. Balasubramaniam, M. B., M. S.,
President.

I. DISEASES OF CARDIOVASCULAR SYSTEM

Dr. Kalyanaraman's Unit

1. Coarctation of the Aorta — Presented by DR. JAYAKUMAR, M. B., B. S.

This is a condition where there is a constriction of the aorta which usually occurs at a point distal to the origin of the left subclavian artery, and just above the point of entrance of the ductus arteriosus. It might take the form of a diffuse narrowing or that of a localised constriction. The degree of narrowing varies.

There are two types of coarctation of the aorta:

1. The ADULT type.
2. The INFANTILE type.

In the *adult type* there is usually an abrupt constriction at or near the level of insertion of the ductus arteriosus. The ductus arteriousus is closed. The blood from the ascending aorta reaches the descending aorta, by a devious pathway of collateral circulation. The prognosis is usually good.

In the *infantile type* there is a diffuse narrowing of the isthmus of the aorta. The ductus arteriosus is patent. The condition is often associated with other cardiac anomalies and the prognosis is very poor.

The adult type is commoner and can be diagnosed clinically for it produces a distinctive clinical syndrome, with the following features:

1. Hypertension of the upper extremities.
2. Weak or absent femoral pulsation.
3. Notching or scalloping of the inferior surfaces of the posterior ribs.

Two cases are recorded below exhibiting the adult type of coarctation of the aorta.

CASE 1:

Name: Ramaswamy.

Age: 24 years.

Occupation: Till recently a clerk in a mill.

History: The patient was a clerk in a mill, where on routine physical check-up, he was discovered to have a cardiac murmur. The medical attendant at the mill referred him to the hospital for investigation.

Previous history: The patient does not remember having been laid up with any serious illness. He gave no history of Rheumatic fever, or pains simulating growing pains, no attacks of sore throat. He has not had any venereal disease.

Family history, habits etc.: The patient is an unmarried Hindu male. He is the third of four male children. All are alive and healthy. The parents are alive and well. He smokes cigarettes very occasionally. He has been educated upto the S. S. L. C. He was fairly active in sports in school. He could run well and had played football for his class for a year. He has not noticed any decrease in his cardiac reserve. He has never felt unduly fatigued or dyspnoic. There was never been any œdema of his feet.

The patient is of moderate habits, has a good appetite and feels fit. It was after this check-up that he was first aware that any thing was wrong with him.

General examination; The patient was found to be a well developed robust young individual of about 25 years.

Height — 5 feet 6 inches.
Weight — 140 lbs.
Chest measurements — inspiration 35 inches.
expiration 33 inches.

He was muscular, well proportioned and well built. He had no anæmia, jaundice, cynosis, clubbing of fingers or toes nor œdema of his feet. His tongue was clean and moist, his throat was healthy, and he had a good set of teeth; the two upper wisdom teeth were yet to erupt. No glands were palpable.

Cardiovascular system:

Pulse. Rate — 70 per minute.
Rhythm — regular.
Volume and tension — good.
Arterial walls showed no thickening.
The pulse was synchronous in both arms and their volumes were equal.

Inspection: The apex heat was visible in the fifth space in the mid clavicular line. No other pulsations were visible over the precordium, or elsewhere over the chest. There were no pulsations in the sternal or epigastric notches. No prominent veins were seen on the side of the neck.

Palpation: The apex beat was visible in the fifth space in the mid clavicular line. No other pulsations were visible over the precordium, or elsewhere over the chest.

Percussion: The heart boundaries were found to be within normal limits.

Auscultation: There was a systolic murmur heard all over the precordium. The murmur was short and rough and did not extend through the entire systolic period. It followed the first sound which it did not replace. The murmur was best heard at the base, and there it was equally well heard on both sides of the sternum. It had no particular line of conduction.

It was also heard over the back, but not as well as over the base of the heart. And though in the front of the chest it was confined in extent to the precordial region, in the back it was heard over a wider area It was heard approximately over an area bounded on either side by the midscapular line above the third dorsal vertebra, and below by the lower rib margins. Beyond these limits it faded away. The murmur did not change its quality or loudness with difference in posture or after exercise.

The heart sounds appeared normal over the valvular areas, except for the fact that in the aortic area the aortic second sound was loud and ringing.

The Blood Pressure was 160/100 on both upper limbs. In view of this high Blood Pressure, in a young apparently healthy adult, his Femoral arteries were palpated. It was found that no pulse was palpable in the femoral artery, the posterior tibial and the dorsalis pedis arteries.

The Blood Pressure could not be recorded in the lower limbs as no sounds could be heard.

The *Respiratory, Alimentary,* and *Nervous* Systems were normal on examination.

Further examination when the absence of femoral pulse was detected showed:

(a) No difference in warmth in the upper and lower limbs.

(b) On making the patient stoop forwards, no collateral vessels could be detected (Suzman's sign).

Investigations:

Urine:	Specific gravity	1015
	Reaction	Acid
	Albumin	Nil
	Sugar	Nil
	Examination of Centrifuged deposit	Nil particular
Motion:	Nil abnormal detected.	
Blood:	Total R. B. C.	4 millions per c. mm.
	Hæmglobin	12·6 gms.
	Total W. B. C.	5600
	Diff. Count:	
	Polymorphs	70%
	Lymphocytes	28%
	Monocytes	1%
	Eosinophils	1%
	E. S. R.	1 hour 5 m.m. (Westergren)
	Circulation Time (Arm to tongue Calcium Gluconate)	Normal

Screening of Chest, elicited the following points:

Anterio-posterior view: The heart was within normal limits and there was no enlargement of the heart boundaries. The pulmonary conus was normal in appearance. The hilar shadows did not show any pulsations. The lung fields were normal in density. The œsophagus on Barium Swallow showed no abnormal markings.

Left Anterior oblique view: The heart was within normal limits and there was no enlargement of the heart boundaries. The pulmonary conus was normal in appearance. The hilar shadows did not show any pulsations. The lung fields were normal in density. The œsophagus on Barium swallow showed no abnormal markings.

Left Anterior oblique view: The left ventricular margin could be cleared of the spine with a rotation of 45 deg. The right ventricular margin was well away from the anterior chest wall. The ascending aorta could be seen well marked out and briskly pulsating. The aortic window was clear. The descending aorta could not be traced.

Right anterior oblique view: The right ventricle was again well away from the anterior chest wall, and the retrocardiac space was not encroached on. The œsophagus on Barium Swallow showed no abnormal markings.

Diagnosis:

In view of the following findings,

1. Hypertension of the upper extremities,
2. Absence of pulsation in the lower extremities,
3. The evidence of collaterals, as shown by the scalloping of the inferior surfaces of the posterior 4th and 5th ribs (Roessler's sign).

4. Good health at 25 years, without associated grave cardiac anomalies, this case is one of Coarctation of the aorta of the Adult type.

In view of the unexpected discovery of a coarctation of the aorta in case 1, it was decided to palpate the femoral artery, whenever the heart was abnormal, or when there was hypertension. This brought to light another case in three months time This pt. also had no complaints and was discovered at a physical check-up of the workers of a motor transport service, done under the auspices of the Red Cross Society.

CASE 2:

Name: Vasudevan. Age 26 years. Unmarried Hindu Male.

Occupation: Bus Conductor.

History: Unlike case 1, this case had very violently pulsatile carotids. Like case 1, however, he had no complaints. But on questioning, he admitted that on exertion, he would feel his heart pounding, and that this condition was existent from the time he could remember. He was also aware of the violent pulsations of his neck vessels, and pulsations in his infraclavicular regions. He has paid no particular attention to them.

His physical capacity was in no way limited. He had no dyspnoea on exertion, though he admitted that his 'wind' was not as good now as it was some years ago. This he attributed to smoking.

He had not noticed that there were no pulsations in the vessels of his lower exremities, which was in sharp contrast to that of his upper extremities and neck.

He did not undergo a medical examination on entering service. He was not aware that he had any cardiac defect.

Previous history: The only major ailment he has had was continuous fever of six days duration, four years ago for which he took some mixtures by sending someone to the hospital. He had no joint pains then. He gives no history of Rheumatic fever. He has had no sore throat, epistaxis or pleurisy. He has not contracted venereal disease at any time.

Family history: He is the only child, and the parents are alive and well.

Habits etc.: He smokes about 15 cigarettes a day. He has studied up to fourth form, and in school, could play about like other children. He has never felt physically handicapped then or now. He is of moderate habits. He has a good appetite, and feels that he is quite fit and well.

General examination: Like case 1, patient is well developed, and appears very healthy and robust.

Height — 5 feet 7½ inches.

Weight — 130 lbs.

Chest measurements — Inspiration 34 inches.
Expiration 32 inches.

Patient is well built and well proportioned. He has no anaemia, jaundice, cyanosis, clubbing of fingers and toes, or oedema of his feet. No glands are palpable. The tongue is clean and moist. The throat is healthy.

Cardiovascular system:

Pulse. Rate — 80 per minute.

Rhythm — regular.

Character shows a sharp rise, and a sudden fall. It is typically 'Corrigans in type'. The collapsing nature of the pulse is accentuated by raising the arm.

The pulse is synchronous in both arms, and have the same character, and the volumes are equal. The arterial walls show no thickening.

The femoral pulse could not be palpated. There were no pulsations in the posterior tibial and the dorsalis pedis also.

Inspection: The Apex beat could be seen in the 6th space one inch away from the left midclavicular line. There were very marked pulsations, synchronous with the heart beat present on either side of the neck, and in the infraclavicular regions.

The pulsations produced a rhythmic nodding of the head.

Palpation: The Apex could be felt in the 6th space one inch away from the midclavicular line. There was a well marked systolic thrill all over the precordium, but best felt at the base. The thrill was also palpable over the carotids on both sides of the neck. No tracheal tug could be elicited.

Percussion: The heart boundaries were found enlarged. The percussion of the left side of the heart extends from one inch away in the second left space to six inches away from the midclavicular line in the sixth space.

Auscultation: A rough rasping loud systolic murmur, extending all through systole, could be heard all over the precordium. It was best heard in the aortic area. The murmur was very loud in this region and was conducted along the carotids. The murmur followed the first sound.

In the aortic area, there was also heard, after the second sound a soft blowing diastolic murmur. This murmur was conducted downwards along the sternal border.

A systolic murmur was also heard over an extensive area, covering practically the whole of the back, from shoulder down to buttocks.

The heart sounds were heard well and distinctly in all the valvular areas.

The Blood Pressure was 200/40 in both the upper limbs. In the lower limbs no blood pressure could be recorded.

There was no pistol shot sound or Durozies' murmur over the femorals. There was no difference in warmth in the two extremities. On making the patient stoop forwards visible pulsating vessels became prominent enough to be seen (Suzman's sign).

The *Respiratory, Alimentary and Nervous Systems* were normal on examination.

Investigations:

Urine	Normal.
Motion	

Blood:

Total R. B. C.	3·8 millions per c. mm.
Hæmoglobin	12·5 gms.
Total W. B. C.	6000 per c. mm.
Differential count:	
Polymorphs	73%
Lymphcytes	22%
Eosinophils	2%
Basophils	2%
Monocytes	1%
E. S. R. (Westergren)	one hour 5 mm.
Blood Kahn	Negative
Circulation time	Secs. (Arm to tongue Calcium Gluconate)

Skiagram and Screening of Chest:

P. A. view. Showed enlargement of the heart especially to the left. The pulmonary conus was not well marked. The Hilar shadows were not very prominent and did not show any pulsations. The lung fields were normal in density. The œsophagus on Barium Swallow showed a normal course.

Left anterior oblique view: The left ventricular margin could be cleared of the spine only after a rotation of about 60 – 70 degrees. The right ventricular margin was well away from the anterior chest wall. The ascending aorta was well marked, and was very briskly pulsating. The aortic window was clear. The descending aorta could not be traced, in its upper part, though lower down, its pulsations could be detected.

Right anterior oblique view: The right ventricle was well away from the chest wall, and the retrocardiac space was not encroached on. The oesophagus on Barium Swallow showed no abnormal markings.

P. A. view for posterior ribs: This showed notching of the inferior surfaces of the posterior parts of the 4th, 5th and 6th ribs, and also a very dilated descending aorta.

This case showed the following features:

1. Signs of coarctation of the aorta of the adult type.
2. Signs of Aortic Regurgitation.
3. Signs of Aortic Stenosis.

These three together constitute a clinical syndrome. The stenosis is probably a congenital sub aortic stenosis.

This case is therefore one of the coarctation of the aorta, with subaortic stenosis and aortic regurgitation.

2. A Case of Mediastinal Syndrome — Presented on 28-2-1953 By Dr. JAYAKUMAR, M. B., B. S.

The mediastinal syndrome may be of two types:

1. The superior mediastinal syndrome,
2. The inferior mediastinal syndrome.

according to whether the area of maximum compression.

The superior mediastinal syndrome arises from the compression of the superior vena cava, vagus, sympathetic, the recurrent laryngeal nerves, the œsophagus and the trachea.

The inferior mediastinal syndrome produces compression of the œsophagus, the inferior vena cava, and the hepatic veins. It is characterised by dysphagia, enlarged liver, ascites, distended veins over the abdomen and œdema of the legs.

A case showing the superior mediastinal syndrome is recorded below:

The superior mediastinal syndrome, or commonly abbreviated as the mediastinal syndrome consists of dysphagia, stridor, paroxysmal cough, hoarseness and dyspnoea, with signs of pressure in the contiguous arteries, veins and nerves. This syndrome is common to many conditions that occupy space, in the mediastinum, for example,

1. Mediastinal new growths,
2. Enlarged mediastinal glands,
3. Aneurysms,
4. Pericardial effusion.

This case had a lymphosarcoma of the mediastinum.

Name and etc.: Rangammal, 34 years, Hindu female, married.

Admitted on 15—4—1953 for dyspnœa and cough.

History: The patient says that she became gradually ill and the total duration of her illness has lasted 6 months. Previous to that she was well. The complaint started with cough. She attended the outpatients department in December 1952. She was screened then and nothing abnormal was detected. Her condition however progressed and her cough became worse and she grew increasingly tired. For the past two months she is dyspnœic. At first the dyspnœa appeared only on exertion. Now it is present even at rest. She cannot lie flat on her back. This position increases her dyspnœa and discomfort considerably. Also during the past month she has been having chest pain that is not related to exertion or cough, the pain being present almost continuously.

Family history: The patient is married, has two children. The husband and children are alive and well. Her parents died of fever in their old age.

Previous history: Nil particular.

On examination: The patient is very ill, ortopnoeic and has inspiratory stridor. She has the bulging stare of dyspnœics. The face is covered with beads of sweat on both sides.

She has a cough which is dry, hacking and brassy. The cough comes in paroxysms. Her face is livid, and the face and neck are œdematus. Her lips are cyanosed. She has no œdema of her feet.

Prominent distended veins are present over the front of her chest and neck and the flow in these are above downwards.

Her voice is normal. A few glands are palpable in the supraclavicular regions. They are hard and matted. The patient prefers to sit up, lying down is impossible, even a back rest being uncomfortable.

She is anæmic and has clubbing of her fingers, she has no jaundice and she is afebrile.

Cardiovascular system :

Pulse: Rate 130 per minute. Rhythm regular. Volume and tension very poor. The arterial walls show no thickening. The pulse was equal and synchronous on both arms. No pulse paradoxus was present.

Inspection : The apex beat is seen in the sixth space one inch outside the midclavicular line. No pulsations are seen in the epigastric or suprasternal regions.

The precordium is normal in shape and there is no bulge. Prominent distended veins are present on the front of the chest. The direction of flow in these as noted above are from above downwards.

Palpation : The apex beat felt in the sixth space one inch outside the midclavicular line. No other pulsations present. No thrills were felt. There was no tracheal tug.

Percussion : There was marked dullness to percussion in an area extending for about two inches on either side of the sternum. On the left side in the sixth space, the dullness extended to one inch outside the midclavicular line.

The interscapular regions between the apex beat and the outermost limit of the dullness on the left side.

Auscultation : The heart sounds were normal and heard well in all the areas.

Blood pressure. 110/70 in both the hands.

Respiratory system :

Inspection : Rate 32 per minute. Both sides of the chest move equally with respiration. No intercostal sucking noted.

Palpation : Vocal fremitus present and normal in all the areas.

Percussion: There was dullness to percussion on either side on sternum and in the interscapular region.

Auscultation : The breath sounds were tubular over the area of dullness. On other areas it was normal. No adventitious sounds were present except for the noisy inspiratory phase.

Whispering pectoriloquy could be heard along the vertebra to the level of the fifth thoracic spine.

On holding the head on extension there was no venous hum over the sternum or the upper part of the chest. (Eustace Smith's Sign).

Abdomen : Not distended. It moves with respiration. There was no shifting dullness or fluid thrill present.

The liver and spleen were not palpable.

Nervous system:

The cranial nerves were all normal.

The pupils were equal, central and reacting to light. There was no evidence of a Horner's syndrome.

The reflexes, the sensory and motor systems were normal.

E. N. T. examination: The vocal cords were normal. There was no paralysis and their movements were normal.

Investigations:

Urine — Nil particular.
Motion — Nil particular.
Blood — Total R. B. C. 2·4 millions per cmm.
Hæmoglobin — 50%.
Total W. B. C. — 10,200 per cmm.

Differential count:

Polymorphs — 60%.
Lymphocytes — 30%.
Eosinophils — 5%.
Basophils — 3%.
Monocytes — 2%.

Erythrocyte Sedimentation Rate — 22 mm. in one hour (Westergren).

Blood Kahn — Negative.

X-ray chart showed a gross tumour in the upper mediastinal region, extending on either side.

Screening of chest: The tumour showed no pulsations. Diaphragm moves normally with respiration. There are no paradoxical diaphragmatic movements. Barium passes freely through the œsophagus.

Biopsy report of the glands in the neck — Lymphosarcoma.

Diagnosis: Lymphosarcoma of the mediastinum.

Course and treatment: The patient was put on a palliative bromide mixture and was given a sedative linctus.

While waiting to be transferred for Deep X-ray therapy, on 19—4—1953, that is four days after admission, she developed a violent dyspnœa at 8 P. M. She was given oxygen, morphia and coramine, but she died at 10 P. M. the same night.

A post mortem could not be done.

3. A Case of Atrial Septal Defect — Presented by Dr. JAYAKUMAR, M. B , B. S.

An Atrial Septal Defect is the commonest non-cynotic congenital Cardiac Disease. There is a defect in the septum separating the two Auricles, thereby allowing a shunt, from the Left Auricle into the Right Auricle. Consequently there is a great right sided enlargement of the Heart. A left sided chest deformity may be present. There is a characteristic Cardiac Contour on X-ray. On screening a Hilar Dance can be visualised

The condition is more often seen in women and the subjects are usually frail and slender. Moreover they are very susceptible to recurrent Lung infections, Rheumatic fever and Cardiac Arrythmias.

Name of patient: Padmakshi. Age: 15 years. Occupation: Student 4th Form.

Complaint: Dyspnœa on exertion, since the time she could remember. This symptom was apparently progressive, and was worse for the past two years. She was not dyspnoec at rest, or with moderate exertion. While in her lower classes could run about and play like any of her other classmates, she was now unable to do this.

Previous history · She was frequently ill. During the past two years she had two attacks of fever and cough, each attack lasting for about a week. On both occasions she was given Penicillin. Previous to these two attacks she was very often laid up. She did not remember exactly the details of these illnesses.

She had no attacks of Tonsillitis, nor any attacks of pain in the joints. She could not also remember ever having suffered from growing pains.

She had not attained puberty as yet.

Family history: Her parents were alive and healthy. She was the product of a full term normal delivery. Her mother was quite healthy when the patient was born. At birth she was not cynosed and apparently was a normal healthy baby.

She has one elder brother and one younger sister. Both are alive and healthy. They have no similar complaints.

On examination: She was a frail girl, of delicate build and with a clear smooth skin. She was not dyspnoeac. She had no Anaemia or Jaundice. She had no Cyanosis or Clubbing of the fingers or toes. The teeth were good, the tongue was clean and moist and the Tonsils were healthy.

Cardiovascular system:

Pulse: Rate 80 per minute. Rythm regular. Volume and tension fair, and equal on both arms. Femoral pulse well palpable. Arterial walls not thickened.

Inspection: There is a very marked precordial bulge. The Apex beat is seen in the sixth space one inch away from the midclavicular line. It was diffuse in character.

The Carotids did not show any marked pulsations. No suprasternal, epigastric or other pulsations visible. The Jugulars were not distended or pulsatile.

Palpation: Apex beat felt in the 6th space one inch away from the midclavicular line. A marked systolic thrill present in the front of the chest, best felt in the second and third left space close to the sternum. No other thrills felt.

Percussion: Left border of the Heart at the sixth space is one inch away from the midclavicular line. The right border is half inch away from the sternal border in the fourth space.

Ausculation: (Apex and Tricuspid areas)—First and second sounds normal and well heard. No murmurs present.

Aortic area: There is a soft systolic murmur, that follows a normal first sound. The second sound is normal. The murmur extends downwards to the third space. There is no particular line of conduction.

The murmur is heard in an area about two inches in diameter which includes the Aortic and Pulmonary areas and extends downwards to the third space on either side of the sternum. It is also audible very faintly in the fourth space. The murmur is best heard between the second and third spaces, where it is loud and fairly harsh. The murmur does not alter in quality after exercise, though it becomes slightly louder. It is best heard on forced expiration with the patient sitting up.

No murmurs are heard at the back or over the Femorals.

Respiratory system:

Rate — 18 per second. The trachea is not deviated. Both sides of chest move equally with respiration. Vocal Fremitus normal. There is no area of impaired resonance. Breath sounds are normal in character in all the areas. Vocal Resonance normal. No adventitious sounds heard.

Alimentary system:

The abdomen not distended. Liver and spleen not palpable. No other lumps felt.

Central nervous system:

Pupils: Equal and react well to light and accommodation.

Jerks: Superficial and deep, normal. Visceral Reflexes normal. Motor and sensory systems normal.

Investigations:

Urine — Sp. Gr. — 1014.
Reaction — Acid.
Albumin — Nil.
Sugar — Nil.
Deposit — Normal.

Blood Pressure — Right Arm — 90/70.
Left Arm — 90/70.
Right Leg — 100/75.
Left Leg — 100/75.

Blood — Total R. B. C. — 3·4 millions per c. mm.
Hæmoglobin — 76%
Total W. B. C. — 5400 c. mm.
Differential count:
Polymorphs — 72%
Lymphocytes — 23%
Eosinophils — 5%
Erythrocyte Sedimentation Rate — 1 hr. 3 mm.
Blood Kahn — Negative.
Circulation Time — seconds (Calcium Gluconate).

X-Ray:

P. A. View: Heart borders enlarged to right and left. There is marked enlargement of the Pulmonary Conus. The Aortic shadow is not prominent. There is marked congestion of the Lung Fields.

Left Anterior Oblique View: There is marked enlargement of the right Ventricle. The left Ventricle is not enlarged. Contours of the Oesophagus, after a barium swallow, did not reveal any abnormality.

Right Anterior Oblique View: Marked enlargement of the right ventricle is seen. The retrocardiac space is encroached. But a barium filled Oesophagus does not show any abnormal Contours.

Screening: The Hilar shadows were very prominent. These were seen to pulsate forcibly. On turning the patient to the left anterior oblique position minimal rotation was all that was necessary to clear the left Ventricular border from the Vertebral Column. In the right anterior oblique position the right Ventricular border was impinging on the anterior Chest wall.

The electrocardiograph shows:

Rate 100 per minute.
Sinus Rhythm.
P waves appear bifid in lead II.
PR interval 0·24 seconds.
QRS — 0·08 seconds.
Right Axis deviation present.
ST segment deflected in leads II & III.
T waves inverted in leads III.

Lead IV shows R S of equal amplitude, and sharply inverted T. (Digitalis effect).

Differential diagnosis:

The following conditions were entertained in the differential diagnosis:

The Murmur has to be differentiated from:

1. Functional and Hæmic Murmurs.
2. The murmur of Ventricular Septal Defect.
3. From the murmur of isolated Pulmonary Stenosis.

The Cardiac contours has to be differentiated from:

1. That of Patent Ductus Arteriosus.
2. That of Eisenmenger Complex.

Functional and Hæmic murmurs: The precordial bulge indicating and enlargement of the heart in early childhood, and the abnormal cardiac contours on skiagram, rule out this condition.

Ventricular Septal Defect: The murmur of Ventricular Septal defect, though also systolic in time is better heard, at a point lower to that of Auricular Septal Defect. Usually in the 4th and 5th left spaces. The Heart does not usually enlarge to such an extent. The Pulmonary Conus is not so prominent and a Hilar Dance does not occur.

Pulmonary Stenosis: The murmur is very loud and harsh. The lungs are not congested, this olægæmic nature of the lung fields being constant.

Patent Ductus Arteriosus: In this condition the Pulmonary Conus may be prominent, and called the Cap of Zinn. The Hilar shadows may also be prominent and also sometimes pulsatile. But here the murmur is of the continuous machinery type and the pulse pressure is wide.

Eisenmenger Complex: This condition might present itself, as an acyanotic condition with a systolic murmur. But in this complex there is no right Ventricular hypertrophy and the Circulation time is decreased, because the blood from the right side of the Heart, may reach the Systemic Circulation through the dextroposed Aorta.

Diagnosis:

The following points favour a diagnosis of an Auricular Septal Defect.

1. The frail slender build, with a left sided chest deformity and a history of repeated pulmonary infections.
2. The enlargement of the right side of the Heart.
3. An enlarged Pulmonary Conus, with a small Aorta.
4. Pleonoemic Lung fields.
5. A Hilar Dance.

Appearance of the patient: This patient as described was frail slender with a clear smooth skin. This appearance is characteristic of this condition. These patients are usually of poor physical development and are described as having a gracile habitut. The onset of puberty is delayed This girl too had not attained her puberty as yet. This characteristic physical appearance is caused by the left to right shunt and the consequent underfilling of the left side of the heart.

Treatment: The only treatment available for the condition is to control Rheumatic infection and to treat the Failure when it arises.

This patient was put on Digitalis, in view of her dyspnoea on exertion. There was only very little subjective improvement.

Conclusions: All the features presented by this patient were characteristic of an Auricular Septal Defect. Nevertheless the possibility of its being a Lutembacher's Syndrome cannot be wholly dismissed. The radiological features of the two conditions are similar in kind and differ only in extent. The absence of a history of Rheumatic fever or any of its variants and the absence of a presystolic murmur suggests the greater probability of this condition being an Auricular Septal Defect.

II. DISEASES OF GASTRO-INTESTINAL TRACT

D. M. O.'s Unit.

1. A Case of Obstructed Incisional Hernia — Presented on 11—4—1953 by Dr. S. Balasubramaniam, M. B., M. S.

Name and etc.: Angathal, 40 years, Hindu, cooly, Kinathukadavu, Pollachi.

Complaint: Swelling left side lower abdomen – of the size of a big coconut.

Previous history: Was operated 10 years ago for an abscess in the region of the present swelling. Sometime after that the patient noticed a bulge in the region which increased on straining or coughing. The swelling has become irreducible for sometime now. Last one week the patient is constipated and micturition is painful. There is vomiting for the last 3 days.

Diagnosis: Obstructed Incisional Hernia.

10—4—1953. Operation: Resection of gut and anastomosis — by Dr. S. Balasubramaniam — under spinal by a horizontal incision skin was separated and the hernial mass was exposed. The peritoneum was opened where it was free exposing a tangled mass of adherent small gut. The coils could not be separated necessitating an excision. The proximal and distal loop leading into the mass was carefully identified and the intervening gut was excised and an end to end anastomosis was performed. The gut was then easily returned to the abdomen.

The planned repair of the abdominal wall was out of the question due to the patient's condition. The peritoneal opening of about 1½" in diameter was closed by overlapping the fibrous sac on both sides.

It was observed that the mesentery of the herniated gut was markedly inflamed with chronic mesenteric adenitis. The intestinal anastomosis was about 8" away from the ileo-cæcal junction. The resected mass of the intestine was found to be about 7' in length.

Apart from little fever the patient had an uneventful post-operative period and was discharged cured on 4—5—1953.

Comments: Though such a large length of ileum as 7' was excised the patient recovered completely and was able to digest a normal meal without any abdominal discomfort at the time of discharge.

2. A Case of Tumour Mesentery — Presented on 14—3—1953 by Dr. (Miss) S. V. Swarnam, M. B., B. S., D. G. O.

Name and etc: Sayammal, 35 years, Hindu, North Coimbatore.

Admitted on 3—2—1953.

Complaint: Repeated attacks of abdominal pain and vomiting. Patient feels a lump moving about in her abdomen.

Duration: 1 year.

Physical examination: Heart and Lungs: N. A. D.
Abdomen: Soft. A firm tumour just below the Rt. hypochondrial region moves somewhat with respiration. More mobile on moving from side to side.

Investigations: Urine: Pus cells and epithelial cells. No R. B. C.

Motion: Roundworm ova present.

Barium Meal – Gastro-intestinal tract – Normal.

I. V. P. Both kidneys start excreting in 3 minutes normal in size.

Blood Group – O.

6—3—53. Operation: Removal of tumour with excision of gut by Dr. S. Balasubramaniam – under spinal. Abdomen opened by a left paramedian incision. A solid spherical tumour little bigger than a tennis ball found in the mesentery of the upper jejunum. On delivery of the tumour it was found that the jejunal mesentery was adherent to the tumour. The attempt at separation of the bowel from the tumour was abandoned for fear of cutting off its blood supply. It was therefore, decided to remove the tumour along with the portion of the gut adherent to it about 4' in length. An end to end anastomosis per distal of the area was performed.

There were a few calcareous glands in mesentery close to the duodenal jejunal flexure. Abdomen closed in layers. The cut section of the tumour showed appearance of a hard fibroma.

300 cc. of blood given during operation. Patient had an uneventful post-operative period and discharged cured on 30—3—1953.

Biopsy Report: Fibroma.

Comments: A solid tumour of the mesentery is an uncommon one. It was at first thought to be a kidney condition but the I. V. P. ruled it out. The safe operative treatment in these cases is excise the tumour with the adherent bowel as was done in this case.

3. A Case of Chronic Intussusception—Presented on 26—9—1953. By Dr D. Lakshmanan, M. B., B S.

Name and etc.: Pattabi Chetty, 22 years, cooly.

Admitted on 28—8—1953 for pain in abdomen with a lump.

Duration: 25 years.

History: Patient gave a history of dysentery for 2 days at the onset, followed by pain in the epigastrium and the hypochondrium.

Present condition: Admitted for pain in the abdomen Vomiting present for the last 7 days Hiccough present. Pain is of the intermittent colicky nature. General condition: Fair. Bowels: Patient has one motion a day.

Local condition: Abdomen soft. No marked degree of distension. There was a transversely situated lump, above the umbilicus, lying across in the epigastrium and the hypochondrium. The lump is tender. Visible peristalsis with increased prominence of the tumour was seen off and on.

Investigations: Motion: pus cells present. No ova or cysts.

Rectal examination: Nil particular.

T. L. C. 16.000. P. 75, L. 24, E. 1.

B. P. 105/75 mm.

Barium enema: Not done.

A clinical diagnosis of an intussusception was made and the patient was operated on 29—8—1953 by Dr. S. Balasubramaniam under light spinal anæsthesia.

Abdomen was opened through a R. P. M. muscle splitting incision. On opening the peritoneum, a transverse lump was found lying in the transverse colon. This was found to be the Intussusception of the ileum, cæcum and colon (Ileo-cæco-colic). The intussusception was reduced by milking the transverse colon. The lower part of the cæcum below the appendix, was the seat of a chronic fibrotic ulcer measuring $\frac{1}{2}'' \times \frac{1}{2}''$. During the reduction of the last part of the intussusception, the ulcer gave way and so the fibrotic edge of this area was excised and the lumen of the cæcum closed in two layers The adherent appendix was removed after separation of the adhesion. The lower coil of the ileum was found adherent to the posterior peritoneum with a band of adhesion and this was released. An ileo-transverse anastomosis (unilateral exclusion type) was performed with closure of the distal stump of the ileum, in view of the weak spot in the cæcal wall. Abdomen closed in layers.

Recovery was uneventful, except for rises of temperature on the 2nd and 5th post-operative days. Motions were not well formed on the 9th day. The patient was discharged on his 20th day, bowels acting twice a day.

Comments: The case is one of a chronic intussusception and inspite of his 25 years duration, the patient's general condition was quite good. Whether the cæcal changes were amœbic in origin and initiated the intussusception could not be definitely said. To avoid any possible risk of a delayed leakage in the cæcum it was considered necessary to do an exclusion anastomosis.

4. A Case of Intussusception in a child aged 5 months — Presented on 24—1—1953. By Dr. S. Balasubramaniam, M. B., M. S.

Name and age: Kalamani, 5 months, Hindu.

Admitted on 31—12—1952 at 6-30 P. M.

Complaint: Pain abdomen; vomiting and passing blood and mucus per anum.

Physical examination: The admitting doctor has noted that a mass was felt on Rt. side of abdomen which was flaccid and not distended. Next morning on 1—1—1953 there was no palpable abdominal mass and the child's general condition was good. But a rectal examination revealed a mass feeling like a cervi uterus and blood on the examining finger.

Abdomen: Palpation sometime later revealed a mass in the left iliac fossa with an emptiness of the Rt. (Sign De Dance).

Diagnosis: Though obvious as an intussusception this was concealed for some time when no mass was palpable per abdomen. Apparently the intussusception gut was lying some what paralysed and without contracting so that no mass could be felt. The rectal examination easily confirmed the diagnosis.

Operation: On 1—1—1953 under ether supplemented with novocain by Dr. S. Balasubramaniam – Rt. paramedian incision apex of the intussusception formed by the ileo-cæcal junction found at the recto-sigmoid colon reduced easily intra-abdominally. There was some little difficulty in reduction in the ileo-cæcal area. Abdomen closed in layers.

Post-operative period fairly uneventful except for slight distension which was relieved by the usual remedies.

The child was discharged cured on 25—1—1953.

5. A Case of Tuberculosis Caecum — Presented on 11—7—1953. By Dr. (Miss) S. V. Swarnam, M. B., B. S., D. G. O.

Name and etc.: Lakshmi, 30 years, Malabar.

Admitted on 8—6—1953

Admitted for lump in the Rt. iliac fossa.

Family history: Married 7 years; no children; periods regular.

Previous illness: Has been having pain in the Rt. iliac fossa for the past 6 years.

History of present illness: Pain has been continuous for the past 1½ years—not related to food. When the pain is acute it is associated with vomiting and passes frequent motions with mucus. Fever present. No cough. Loss of weight.

Condition on admission: Anæmic. No palpable glands neck.

Heart and Lungs: Nil abnormal.

Abdomen: There is a palpable mass in the R. I. Fossa fixed and tender.

P. V. Cervix and uterus: Normal, mobile.

There is fullness in the Rt. fornix.

Blood Group: A6.

Hb.: 80.

Blood: T. L. C. 11,000 ccm.

D. L. C. 74% P, 21% L, 5%

Sedimentation Rate: 1st hour 67 mm.

Motion: No ova.

Urine: Nil abnormal.

B. P. 105/75

12—6—1953: Barium enema does not flow beyond hepatic flexure.

15—6—1953: Barium meal suggested defective filling of cæcum and ascending colon. Tuberculosis cæcum.

10—7—1953: Operation — Unilateral Exclusion Ileo-Transversostomy by Dr. S. Balasubramaniam. Under spinal, abdomen was opened by Rt. paramedian incision. The entire ileum was studded with tubercles small and big. The ileo-cæcal junction was a hard mass covered by fibro-fatty tissue-about the commencement of the ileum-there was found to be an impervious stricture and so it was decided to resect and do an end to end anastomosis here alone. The rest of the ileum had no strictures though they were covered with tubercles. For short-circuiting the stricture at the ileo-cæcal junction, a unilateral exclusion end to side anastomosis was performed. The end of the ileum was implanted on the transverse colon. Abdomen closed in layers.

Biopsy Report: Tubercular Infection Cæcum.

6. A Case of Obstructed Hernia — Presented on 28—11—1953 by Dr. D. Lakshmanan, M B., B. S.

Name and etc.: Arunachalam Chettiar, 33 years.

Admitted on 25—11—1953.

The patient was admitted for a not too painful swelling of the Lt. Inguino-scrotal region and complained of dyspepsia with belching. Not constipated. No vomiting. General condition: good. Duration: since birth.

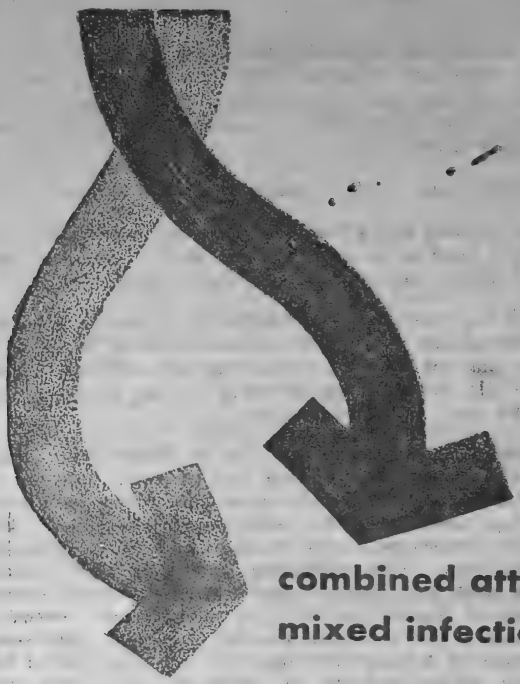
Local condition: A tense swelling occupying the Lt. side of the scrotum and inguinal canal, upto the external inguinal ring. The swelling was not reducible; dull on percussion; no impulse on coughing. The testis could be palpated through the swelling. Trans-illumination – negative. Testis and cord: normal. No evidence of phimosis or stricture.

Heart and Lungs: Nil abnormal. Urine: normal. B. P. 110/98.

History: Of the scrotal swelling being present before and getting reduced. Prior to admission, patient had been to his doctor in his home town for non-reducibility of swelling and the doctor had apparently reduced the swelling.

The case is presented for the reason that a definite pre-operative diagnosis could not be arrived at. Though the history of a hernial swelling was kept in mind, a diagnosis other than that of a hernia was thought of. The conditions that were thought of, were (1) inflammatory affection of the cord (filarial); (2) diffuse tense hydrocele of the cord; (3) lymph varix.

27—11—1953: Operation — Herniorraphy by Dr. S. Balasubramaniam. Under light spinal anæsthesia, the left spermatic cord was exposed, through an inguinal incision and a dermal sac was identified and exposed, containing omentum. The sac was of the congential type containing the testicles and contents. The inner wall of the sac showed four transverse constrictions, which was responsible for the incarceration of the omentum. The redundent omentum was excised, sac violated and exoised at the neck and herniorraphy done. The usual causes of obstruction to and fro passage of hernial contents are the adhesions between the contents of the sac or between the contents themselves. The interesting feature in this case, is the presence of 4 transverse ridges on the inner wall of the hernial sac which accounted for non-reducibility of the omentum, which was locked up as it were in segments. It cannot be stated whether the transverse ridges or constriction, represent the natural attempt at closure of the furnicular process of the peritoneum.



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III. OBSTETRICS AND GYNÆCOLOGY

D. M. O.'s Unit.

1. A Case of Full Term Abdominal Pregnancy (Intraligamentary) — Presented on 12—12—1953 by Dr. (Mrs.) Anna Vareed, F. R. C. S., etc.

Name of patient: Periakkal. Residence: Perianaickenpalayam.

Age: 23 years.

Admitted: 3—1—1954.

Discharged cured: 27—1—1954.

Previous history: 2 previous pregnancies, both normal. Labour both normal. Only one child aged 3 years, alive and well now.

Present history: Pregnant; amenorrhœa of 12 months' duration according to her dates. When about 6—7 months' pregnant, she came to hospital, complaining of rather severe pain lower abdomen, no vaginal bleeding or discharge. Admitted to ante-natal ward for observation. Sedation and rest in bed prescribed. Pain subsided. Nothing abnormal was then discovered, case considered to be one of normal pregnancy. Patient discharged after 4 days and advised to attend ante-natal clinic regularly. Patient kept good health till she was again admitted to ante-natal ward in December 1953.

Complaint: Pain all over abdomen. 12 months pregnant. No fœtal movements felt for a week. Abdomen feels very hard and tense.

Examination: P. A.: A hard very tense tumour in the middle line, reaching to about a hand's breadth above umbilicus, not movable. Fœtal parts not made out. No fœtal movements felt and no F. H. heard.

P. V.: Normal size non-pregnant cervix felt, more on the left side. Normal uterus felt also more on the left side. A fulness in the right fornix. Otherwise N. A. D.

Per speculum: Cervix healthy, non-pregnant appearance. No discharge. Vagina healthy.

X-Ray: A full term well developed fœtus head above and breach below indistinguishable from a normal uterine pregnancy. Spalding's sign of fœtal death (i. e., overlapping of skull bones) present.

Diagnosis: Abdominal, full term pregnancy with fœtal death.

Blood Grouping: 'O' Group.

Advised: Abdominal section and prepared for operation next day, but patient left hospital on 18—12—1953 (absconded).

Readmitted: 3—1—1954 into Surgical Ward; willing for operation.

Operated on 5—1—1954.

Anaesthesia: Local novocaine infiltration supplemented by Gas and Oxygen.

Operation: Sub-umbilical median incision (the sub-umbilical area was very much larger than normal, the distance from umbilicus to pubis being about 10").

Abdominal cavity opened into, omentum with fat necrosis in several places, found adherent to the parietes and to the gestation sac which simulated a full term pregnant uterus in the middle line. The sac was incised and a full term dead female fœtus was removed, weighing 7½ lbs. The umbilical cord had completely disappeared due to the absorption of Wharton's jelly and its contents. The placenta shrivelled up was found as a thin layer lining the upper part of the gestation sac which was formed by the amnion, chorion and the layers of the right broad ligament, the right tube being stretched over the sac as is seen in a case of broad ligament cyst. The gestation sac was completely excised, and the broad stump left was peritonised, after the stopping all bleeding. The uterus, the left tube and left ovary were found to be quite healthy and normal and were left behind.

The raw area at the base of the gestation sac as well as the parietes were drained. Peritoneal cavity mopped dry and clean. Abdomen closed in layers. Patient was given a pint of blood during the operation.

Penicillin 5 lakhs daily given for the first 4 days. Drainage tubes removed after 48 days.

Patient had a normal post-operative period and made an uneventful recovery.

General condition quite good.

Discharged cured on 27—1—1954 and advised to avoid a future pregnancy for at least 6 months and to come to hospital for periodic check-up.

2. **A Case of Tubo-Ovarian Mass with a fœtus inside**—Presented on 21—11—1953 by Dr. K. G. Janaki Bai, M.B., B.S., D.G.O.

Name and etc.: Chinnammal, 30 years, Hindu, Alandurai.

Admitted on 28—10—1953 at 11-55 A.M.

History: Has two children 5 and 3 years old. Menstrual history—scanty periods for the last 3 years lasting only a day.

Complaint: Pain in the lower abdomen.

Duration: One month; was discharged from hospital after treatment for the same complaint only a week back. Pain has recurred.

Physical examination: General health fair.
Heart and Lungs: N. A. D.
Abdomen: A soft small tender mass felt in the lower abdomen more on the left side.

Pathological report: Urine—normal.
Cervical Smear: No g. c.
T. L. C.: 21,600/cm. m.
D. L. C.: P. 82%; E. 12%; L. 6%
B/p: 115/75.

Operation and treatment adopted: Under light spinal abdomen opened by a sub-umbilical incision by Dr. Janaki Bai. A cystic mass was found adherent all round on all sides and on the Rt. to the appendix and colon on upper part of the uterus.

The cystic mass was slowly released by blunt dissection all round and removed. The Rt. tube also found œdematous and unhealthy. Lt. Salpingo-oophorectomy and Rt. side salpingectomy was done. Appendicectomy was also done, and the abdomen closed in layers. Drainage tube put in before closing in layers.

The specimen of cyst on opening revealed a fœtus of 5 months size with cord and placenta fixed inside the capsule.

Disease: Pelvic cellulitis. Ovarian Cyst.

The interesting feature about the case is in the diagnosis. The condition before operation was thought to be one of inflammed ovarian cyst. But actually it was left tubal gestation with that of the fœtus and formation of an adventious sac around it.

Patient was discharged cured on 8—12—1953.

IV. DISEASES OF SPLEEN, LIVER AND GALL BLADDER

D. M. O.'s Unit

1. A Case of Gall Stones — Chronic Cholecystitis with Gall stones — Chronic Appendicitis — presented on 27—6—1953 by Dr. (Mrs.) Anna Vareed, F. R. C. S., etc.

Name and etc.: Arputhamary, 40 years, Christian, Fort, Coimbatore.

Duration: 12 years.

Complaint: Pain in the Rt. ileac fossa, 6 months. Chronic dyspepsia 15 years. Pain after meals. Distension. Afraid to take solid food. Hiccough. 12 years duration.

Admitted on 16—5—1953.

Pathological report: Motion examination: No ova.
Urine: Sugar and Albumin: Nil.
Blood: T. L. C. 9,800/cm. m.
D. L. C. P. 55%; L. 31%; E. 14%.
B. S. R. 1 hr. 25. 2 hrs. 60.
BA Meal: No evidence of peptic ulcer.
Appendix not visualised.
B/p. 108/75.

8—6—1954: *Operation*: Cholecystemosis and Appendicectomy by Dr. S. Balasubramaniam — under light spinal. Rt. para median incision. No ulcer in the stomach or duodenum. A small embedded appendix removed Gall bladder distended, inflammed with hour-glass contraction; aspirated 35 c. c of dark thick bile was removed and gall bladder was dissected out and removed. Raw area on the liver was peritonised; as there was still some oozing spongistan was applied and left *in situ*. Abdomen closed in layers. The specimen of gall bladder contained one large stone of the size of a cherry and several dark green smaller stones.

Except for slight fever the patient had a quiet post-operative period and discharged cured on 29—6—1953.

Comments: The patient was not investigated for all bladder though her dyspepsia is more in accord with that condition, rather than peptic ulceration. Though on common in this part of the country gall bladder pathology as a cause of surgical dyspepsia should be kept in view by every operating abdominal surgeon.

2. A Case of Perisplenic Hæmatoma — presented on 22—8—1953 by Dr. D. Lakshmanan, M. B., B. S.

Name and etc.: Duraiswamy, 25 years.

Admitted on 12—8—1953 in the Medical Ward.

Patient was admitted for fever with a painful swelling in the Lt. subcostal region.

Duration: 5 days.

History: Patient gives a history of swelling being present in the Lt. subcostal region for the last one year, gradually increasing in size. Gives a history of filarial attacks with œdema of the Rt. leg and foot. No history of malaria or any bleeding tendency. Prior to admission in this hospital, patient was treated in Dharapuram Hospital. Patient gives a history that the swelling in the abdomen was aspirated.

Patient was transferred to the Surgical Ward as the patient was feeling worse and temperature was not responding to the usual antibiotics.

General condition: A thin individual, apparently ill, running an irregular temperature, ranging from 100–102° F. Tongue moist and coated.

Local condition: Abdomen moves with respiration. A painful rounded lump in the Lt. hypochondrium below the subcostal region, moving with respiration. Dull on percussion, continuous with splenic dullness.

Other systems: Nil abnormal.

Investigations: Urine: No albumin or sugar. Few R. B. C. and pus cells.
Blood: Negative for M. P.
T. L. C. 23,500.
D. L. C. P. 83, L. 17.
Blood for microfilaria: Negative.
Motion: R. B. C. few. Pus cells few.
Screening diaphragmatic levels and movements: Normal.

During the five days, the patient was being treated in the surgical side, it was noticed the swelling was increasing in size, rapidly with increasing pain. A fluid thrill was elicited over the swelling.

In view of the history of trauma (i. e., aspiration with a needle) splenitis with peri-splenitis giving into suppuration was thought off. The other conditions that were considered were an infected hydatid cyst and an abscess of the Lt. lobe of the liver.

24—8—1953: *Operation*: Incision and drainage by Dr. V. S. Gopalakrishnan under local anæsthesia the swelling was explored through a Lt. oblique subcostal incision. The swelling was exposed by cutting the abdominal muscles. A needle was put in and aspirated chocolate coloured fluid. Through a trocar and canula, 1½ pints of similar fluid was aspirated. The opening was enlarged and the cavity was found to be walled off by adhesions and extra-peritoneal After mopping up the fluid contents, the spleen was identified at the depth of the wound, moving with respiration and had a laceration on the outer surface. A drainage was put in and wound closed in layers. A post-operative diagnosis of laceration of spleen with perisplenic hæmatoma was made.

The patient made an uneventful recovery and was discharged at the end of three weeks.

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SHARP & DOHME

V. DISEASES OF THE KIDNEY & BLADDER

D. M. O's Unit

1. Three Cases of Hydronephrosis — Presented on 27—6—1953 by DR. E. RAJUVEDAN, D. M. & S.

Case No. 1 :

Name and etc: Raghothama Rao, 35 years, Vaccinator. Admitted on 8—12—1952.

Complaint: Pain Lt. side of the abdomen.

Duration: 6 year.

Family history: Nil special.

Previous illness: Dysentery in his boyhood. He had repeated attacks of colicky pain Lt. side of abdomen, sometimes attended with distension and at other times not.

History of present illness: Sometimes he might vomit, if not he had to induce vomiting, which relieved him of the pain. Pain often experienced 3 hrs. after taking food, which lasted for 6 to 15 hours. Sometimes he used to get sudden relief. Pain is not relieved by taking any food—there was no history of (1) radiation of pain (2) hæmetemesis (3) hæmaturia (4) any complaint regarding micturition and defæcation. He stated that he was seen and treated by many a medical man for peptic ulcer and amœbic dysentery as no laboratory investigations were done.

Condition on admission: Fairly nourished; not anæmic; apyrexial. Patient was not able to locate the pain but was pointing to the whole Lt. side of the abdomen.

Abdomen: Soft; no rigidity. No tenderness. During episodes of colic, careful bimanual palpation of left loin revealed a soft cystic swelling suggestive of hydronephrosis. Not discernible in intervals.

C. V. S.: N. A. D.

Nervous system: N. A. D.

Respiratory system: N. A. D.

Blood: TLC 7,600.
P. 24%; M. 1%; Lymph. 35%.
Group A.
Hb. % 75.

Blood Urea: 38 mgm. %.
B. S. B. 1 hour—2 mm. After 2 hours—4 mm.

Urine: Sugar and albumin: nil.
Few R. B. C. and few pus cells. No casts.

I. V. P. was done. Delayed excretions in both kidneys. Excretion was seen in the Rt. kidney after 20 minutes and calyces and pelvic were visualised. In the Lt. kidney excretion was seen after 65 minutes. Calyces and pelvis were not defined.

Operation: Nephrectomy by Dr. S. Balasubramaniam—Under light spinal. Extraperitoneal oblique Lt. lumbar incision. The kidney was seen completely converted into a huge bag of fibrous sac which could be removed only after tapping the fluid inside the sac.

The patient was discharged cured on 25—3—1953.

The important points which are to be noted in this case are (1) the patient wandered hither and thither for 6 years for the relief of this condition but he was treated for peptic ulcer and amœbic dysentery (2) though the hydronephrotic sac was an enormous one it was difficult to palpate accurately most of the time (3) the cause of hydronephrosis, i. e, no cause for the obstruction could be found. Incidentally it is worth to be mentioned here that the cases showing very great dilation are nearly always those in which no obstruction is found (Idiopathic group).

Case No. 2:

Name and etc: Thangavelu, 34 years, Hindu, ryot.

Admitted on 20—4—1953.

Complaint: Colicky pain Lt. loin.

Duration: 2 to 3 years.

Family history: Nil special

Previous illness: Nothing special.

History of present illness: Started with vague dull aching pain over the lt. loin. But once in a way the pain used to be very severe and agonising and it would radiate towards the testis. Whenever he had severe attack, either he had nausea or vomiting. He was admitted and treated for renal colic in Govt. Hospital, Dharapuram. He had one severe attack a month prior to admission to this hospital.

Condition on admission: Patient looks ill and weak; slightly anæmic. As mentioned before, he gives a typical history of renal colic.

Abdomen: Soft; no mass felt anywhere. Tenderness over the Lt. Renal angle behind. Spleen and Liver are not palpable.

Testis and external meatus: Normal.

Other systems: N. A. D.

Investigations:

Urine: R. B. C. ++++
Pus cells. +++
Few phosphate crystals.
No casts.

Blood: DLC. P. 65%; L. 26%; E. 8%; M. 1%.
Hb% 70%. Blood Urea 38 mgm.% Group. O.

X-Ray: Plain picture of abdomen was taken for K. U. B. and it showed nothing abnormal.

I. V. P.: Was done. Both kidneys excrete in 7 minutes. Rt. kidney appears normal. Lt. kidney's calyces appear very much distended.

B. P.: 120/95.

Operation: Nephrectomy by Dr. S. Balasubramaniam—Under light spinal—oblique incision of Morrison type. The kidney was hydronephrotic and found to be very much enlarged, the upper pole of which was adherent to the diaphragm.

The patient was discharged on 2—6—1953.

Comments: This is also a case of idiopathic hydronephrosis, but the diagnosis was straight forward and not a problem as in case (1).

Case No. 3:

Name and etc: Krishnaji Rao, 35 years, Hindu, tailor.

Admitted on 17—6—1953.

Complaint: Vague pain over the epigastric region.

Duration: 6 to 7 years.

Family history: Nil special.

Previous illness: History of Dysentery 3 or 4 times within the past 2 years; last attack being 2 months prior to admission to this hospital. History of gonorrhœa and syphillis 15 years back. Had treatment for both the above mentioned condition but no body had suggested about his renal condition as he had no disturbance of bladder function; no difficulty with micturition; no hæmaturia. In short he did not show any signs and symptom referable to kidney.

Present illness: Started 6 to 7 years back with dull aching pain over the epigastric region sometimes aggravated by exertion. It may continue for hours or it may suddenly subside, but a sort of unexplainable discomfort would persist over the same region. At no time he had acute colicky pain. The pain had no relation to food He had no vomiting. For the past 15 days the pain is so severe that he came to the hospital for treatment.

Condition on admission: Well nourished; appetite poor, but cannot relish the food; tonsils not enlarged. Not anæmic. Abdomen moves with respiration; no bulging is seen anywhere. A soft elastic swelling is felt over the Rt. hypochondriac region. It is movable bimannually. The swelling is not continuous with the liver dullness. Spleen and liver not palpable.

Other systems: N. A. D.

B. P. 115/70.

Blood: Kahn—negative. T. L. C. 8,200.
P. 60; L. 32; E. 8.
Hb. 80%.

I. V. P. 8 minutes Rt. not excreting.
25 minutes Rt. do.
45 ,, Calyces seen.
1 hour Calyces enlarged.
Lt. excreting normal.

Hydronephrosis was diagnosed and it was suggested to the patient that he might have to undergo an operation. He was willing for the operation but left hospital before it could be done.

2. A Case of Tumour Kidney — presented on 27—6—1953 by Dr. (Miss) S. V. Swarnam, M. B, B. S, D. G. O.

Name and etc.: Ruckmaniammal, 38 years.

Admitted on 4—6—1953, for pain abdomen for 8 years.

Family history: Married 15 years. Number of children 3. Last child 5 years old. Periods regular.

History: Started 8 years ago with vague abdominal pain unconnected with intake of food. Whenever she had pain abdomen she used to have loose motion 3 or 4 times. Micturition normal.

General condition: Thin patient; not anæmic. No palpable glands neck.

Heart and Lungs: Nil abnormal.

Abdomen: A visible tumour moving with respiration in the left hypochondrium.

Palpation: A soft regular tumour is palpable in the left hypochondrium; the lower margin is regular, rounded and extends up to the umbilicus. No tenderness. Dull on percussion. Liver not palpable. No free fluid in the abdomen. No area of resonance behind the tumour.

Pathological report: B. P. 170/100.

Urine: Clear. Sp. Gr. 1002. Reaction: alkaline.
No sugar. Albumin traces.

Motion: H. W. ova present. Deposits only phosphatic crystal.

Blood: Sed. rate; 35 mm. 1st hour; 71 mm. 2nd hour.
Group 'O'
Hb% 80.
R. B. C. 4·12 mill.
Total W. B. C. 10,240.
P 75%; L. 17·5%; M. 1%; E. 6%.

Sputum: No A. F. B.

Blood Urea: 30 mg.

Blood Kahn: Negative.

X-Ray Lungs: No active lesions.

I. V. P.: Tumour left kidney.

29—6—1953: *Operation*: Nephrectomy by Dr. S. Balasubramaniam. Under general, the usual extra-peritoneal kidney incision; as the tumour was too big to be delivered, the 12th rib had to be resected to get more space. Nephrectomy was done and wound closed with a drain.

Naked eye appearances: The tumour was of the size of 8″×6″×6″ with a small portion of the kidney in the lower pole not being involved. Section shows dark brown fluid and degenerating soft tissue.

Patient had an uneventful post-operative convalescence. Wound healed by 1st intention. Discharged cured.

Biopsy report: Hyper nephroma.

3. A Case of Hydronephrosis — Presented on 12—12—1953. By DR. D. LAKSHMANAN, M. B., B. S.

Name and etc: Ardhanari Chettiar, 48 years, weaver.

Admitted on 2—12—1953.

Duration: 6 years

Patient was admitted for a cystic swelling the Lt. Loin and lumbar region extending towards the umbilicus and the Iliac Fossa. Swelling moves with respiration. Not painful. Fluid thrill present.

Patient complained of heaviness in the belly, dyspepsia, constipation and occasional attacks of bleeding per rectum for the last 3 years. He used to complain of dimness of vision, now and then.

Investigation: Urine: No albumin or sugar.

B. P. 150/90 on admission.

Plain X-Ray: Revealed diffuse opacity in the Lt. and upper quadroma. No evidence of calculus.

I. V. P No excretion of the dye on the Lt. side. Lt. Kidney not excreting and not visualised Rt. kidney excreting.

Blood urea: 100 mgms. % RBC. 3 millions. Hb% 60.

Examination of Fundus: normal. Rectal examination: 2 small piles seen at the 7 and 11 o'clock position.

In view of the high blood urea and low Hb% patient was treated for anæmia with liver extract on alternate days. Glucose with Vitamin C was given daily for 7 days. Subsequent examination of blood urea revealed lowering of blood urea to 60 and then 40 mgms. Meanwhile the patient was getting impatient and homesick. The blood pressure as recorded on 12—1—1954 showed a fall to 130/82.

12—1—1954: Operation—Nephrectomy by Dr. S. Balasubramaniam. Under light spinal — 11 c.c. – the hydronephrotic sac was exposed through the usual kidney incision, the sac was aspirated through a trocar and canula. 5 pints of straw coloured fluid (urine) was drawn out, the size of the sac reduced. After clamping the Renal pedicle and ureter, the sac was removed. The ureter had snapped during the earlier procedure of separation of the sac. After removal of the entire hydronephrotic sac, the wound was closed in layers with a drainage.

Comments: The case is presented as an example illustrative of the so-called Idiopathic Hydronephrosis, where no apparent cause of obstruction could be demonstrated at operation. In this particular case, there was no evidence of stone or evidence of an aberrent renal vessel. The ureter was apparently normal. Neuro-muscular in-co-ordination at the pelvic ureteric junction has been postulated as a probable cause for this type of hydronephrosis. It has been the experience in this hospital that most of the cases of hydronephrosis in adults are unilateral and of the idiopathic type. The presence of hypertension in this particular case is probably related to the hydronephrosis.

4. A Case of Tuberculosis of Kidney: Presented on 26—9—1953 by DR. V. S.. KESAVAN, B. SC., M B., B. S.

Name and etc : Pongiammal, 35 years, Hindu, cooly, Kitanpuliyur.

Admitted on 10—8—1953.

Duration: 6 months.

Pain abdomen and irregular fever – duration 6 months. Pain dull aching type over left lumbar region; gradual emaciation. No cough; pain present constantly. No relation to food. Not relieved by food. No acid eructation. Appetite poor. Bowels constipated.

General condition: Emaciated and ill nourished; anæmic, otherwise nil particular. Alimentary system and abdomen: Abdomen soft; oval lump 4" x 3" present in the left lumbar region corresponding to the left kidney. More or less fixed. Slightly tender. Liver and spleen not palpable. No other lump palpable. C. V. S & Respiratory System: Nil abnormal. P. V.: Nil particular.

Pathological Report: B. P. 90/55.

Urine: Albumin trace, no sugar, microscopic examination; R. B. C. present. Pus cells +++. No casts. Centrifuged deposit for presence of A. F. B.: Negative repeatedly.

Blood: T. L. C. 33,000/cm. m
Smear: No M. P.; leucocytes +.
Hb% 70.
Total R. B. C. count: 3·8 millions/cm. m.

I. V. P. Hydronephrosis left with multiple calculi in the lower pole. Rt. kidney appearance normal.

Blood Urea: 40 mg /cm. m
Blood Group: B.

Patient was treated for anæmia and blood transfusion given.

21—8—1953: *Operation*: Nephrectomy by Dr. S. Balasubramaniam; under light spinal anæsthesia Thompson-Walker extraperitoneal lumbar incision. The superficial muscle layer cut along the line of incision. Even while reaching the deeper muscle layers, they were found chronically inflammed and indurated. The deeper muscles, perinephric tissues and kidney were all in one mass giving an yellow cheese-like appearance. The indurated perinephric tissue was broken through by blunt dissection and exploration done The twelth rib was excised to facilitate the operation. The peritoneum could not be pushed away, being adherent both in front and above. The peritoneum deliberately opened and mass explored. The kidney was reached by breaking through the capsule and the kidney was removed intracapsularly by clamping the pedicle. The capsule and the perinephric tissue left, looked so badly diseased, so this was also dissected off. There was some difficulty at getting at the vessels at the pedicle from the indurated tissue. The peritoneum closed after keeping a drainage tube at the lowest position. Muscles closed in layers after keeping a rubber drain. Skin closed in layers.

Cross-section of excised kidney: appearance that of tubercular pyonephrosis with areas of caseation and calcareous deposits. Capsule very thick and adherent with perinephric tissue.

4251/53: *Pathological report*: Kidney: tubercular pyonephrosis.

Post-operative period: normal. A small sinus was present at the place of drainage tube. No discharge from the sinus. Patient was continued i. m. Streptomycin ½ gm. daily to begin with and later ½ gm. on alternative days, Isonex tablet 1 t.d s. to a total of 15 gm. streptomycin. Sinus gradually healed. Patient was picking up her general health and putting on about 12 lbs. Patient was discharged on 2—10—1953.

5. A Case of Vesical Calculus—presented on 31—10—1953 by DR. C. T. SIMON, B. A., M. B., B. S.

Name and etc: Karuppa Gounden, 50 years, Hindu, Shop-keeper, Marukka, Pollachi Taluk.

Admitted on 20—10—1953.

Duration: 2 years.

The patient was admitted for (1) frequency of micturition (2) pain and (3) hæmaturia.

History: Had gonorrhœa 2 years ago for which he was treated with injections. The complaint started 2 years ago. The frequency was progressive and the desire to pass urine was urgent and imperative. Even after passing urine he still had discomfort and a feeling that the bladder was not empty. These symptoms were aggravated by movements. Pain was a prominent symptom. It occurred at the end of micturition and was referred to the tip of the penis. It was sharp and cutting and was more while moving about. Hæmaturia was terminal. At first the blood was bright red. Later it was mixed with urine. No history of renal colic or retention of urine.

Local condition: A hard fixed mass felt in the suprapubic region. On P. R. the hard mass felt. No enlargement of the prostate.

Etiology: (1) heredity (2) diet with lack of Vit A (3) urinary infection (4) urinary states (5) congenital abnormality of the urinary tract (6) climate and locality (7) age and (8) sex.

Pathological report: Urine: R. B. C. +++ Pus cells ++
No casts. Albumin and Sugar: Nil.
Blood for Kahn: Negative.
B. P.: 120/80.
X-Ray. Large Vesical Calculus visualised.

28—10—1953: *Operation*. Supra-pubic lithotomy by Dr. V. S. Gopalakrishnan. Under light spinal. Bladder opened by a long incision. The stone was found adherent to the bladder wall which was separated. Stone pushed upwards from the rectum and delivered by applying forceps. Continuous drainage put in.

Stone: Hard, smooth, large stone weighing 15 ozs.

The patient was discharged cured on 5—12—1953.

VI. DISEASES OF NERVOUS SYSTEM

Dr. Menon's Unit

1. A Case of Flourosis with Quardiplegia — presented on 14—2—1953 by DR. N. SUBRAHMANYAN, M. B., B. S.

Name and etc.: Thirumoorthy, 45 years, Hindu, Angalakurichi, Pollachi Taluk.

Complaint: Inability to use both lower limbs, 2 years. Had similar trouble in the upper limbs which has improved slightly. Pain in the back. No history of injury. No fever or cough.

Bladder: Control normal.

Bowels: Constipated.

No history of V. D. Married; has 5 children.

No case of similar nature in the locality.

Condition on examination: Has a mask-like expression. No tremors of eyelids or tongue. No nystagmus. Whole spine is stiff. Has some irregular growth over medial border of Rt. tibia. Pupils — normal. Teeth — mottling present.

Nervous system: Cranial nerves — normal.

Spinal system - Motor - Tone good. No wasting of muscles. Has marked clasp-knife rigidity of lower limbs and left upper limb.

Reflexes — Ankle and knees — jerks exaggerated; clonus present. Plantar — extensor. Abdominal reflex — absent.

Biceps, triceps and supinator — exhaggerated.

Sensory — Fire touch and pin prick lost below about the middle of both thighs; Temp. — sense lost below middle of both the legs.

Other systems: Normal.

Investigation: Blood Kahn: negative.

C. S. F. Cells 18/cm. m.
Proteins 60 mgm.%
Globulin — Negative.
Kahn — Weak positive.

X-Ray spine shows increased calcification over all the vertebra.

A sample of water (well) from the locality showed increased flourine content.

Disease: Flourosis with quadriplegia.

Differential diagnosis: Albers Schonberg Disease with quadriplegia.

2. Case of Acute Polyneuritis (?) due to Syphilis — Presented on 28—2—1953 by DR. N. SUBRAHMANYAN, M. B., B. S.

Name and etc: Abdul Razak, 35 years, Muslim.

Admitted on 20—2—1953.

Complaint: Inability to walk; weakness of upper limbs.

Duration: 20 days.

History of present illness: Gradual onset beginning with the left lower limb with pain in the limbs; slight fever; no fits or history of injury. Visceral reflexes—unaffected.

Previous illness: Nil particular.

Family history: No history of V. D.

Condition on examination: Fairly well nourished; cannot walk due to flaccid paralysis of lower limbs. Has fine tremors of tongue. Pupils equal and reacting to light. No neck rigidity.

Nervous system: Speech normal; intelligence good.

Cranial nerves: N. A. D.

Spinal system — Motor — Has flaccid paralysis of lower limbs and weakness of upper limbs. Muscular tone poor.

Tendon reflexes — knee jerk and ankle jerk lost on both sides. Plantar — indefinite.

Biceps, triceps and supinator jerks — weak. Superficial reflexes — abdominal and reflexes — brisk.

Sensory: Anæsthesia to pin prick and fire touch below middle third of both legs and fingers of both hands. No tropic lesions.

C. V. S.: Apex beat, just lateral to left nipple line in the 6th space' forcible. No murmurs. B. P. 130/80. Pulse and arteries: N. A. D.

Lungs: Clear.

Abdomen: Soft; liver and spleen — not palpable

Investigations: No fever in hospital.
Urine, blood smear, stools — N. A. D.
Blood Kahn — Negative.
C. S. F. 130 cells/cm. m.
Proteins 120 mgm. %
Globulin +
Chlorides 720 mgm. %
Sugar 74 mgm. %
No organisms.
C. S. F. Kahn — Positive.

Disease: Acute Polyneuritis (?) due to syphilis.

Progress and treatment: A course of P. A. M. 6 lakhs daily for 14 days was given with weekly bismuth injections.

Patient improved, left the hospital walking.

VII. DISEASES OF ENDOCRINE GLANDS

Dr. Kalyanaraman's Unit

1. A Case of Lawrence Biedl Moon Syndrome — Presented by Dr. Jayakumar, M. B., B. S.

This syndrome is familial affecting several members of the same family and shows many of the following characters.

1. Frohlichs Syndrome.
2. Retinits Pigmentosa.
3. Feeble Mindedness.
4. Polydactylysm.
5. Occasionally other congenital defects.

It is said that this syndrome is confined to the Hebrew and the Caucasian Races, and that in many cases, they are the products of consanguinous marriages.

Name of patient: Subramaniam. Age 10 years.

Complaint: The patient had no complaint. He was admitted into the Hospital for the treatment of bulkiness and lethargy. The patient was aware that he was unduly fat, as the other boys in the school used to make fun of him. He was fat from birth. Also he could not see well in the night.

Family history etc: He was the third of the four children in his family. All are alive and well. He is the only fat one. The rest are normal and healthy. His two elder brothers are educated. His younger brother, younger to him by three years, studies in the same class as the patient. The patient had failed in his class several times and had always bad rank.

His younger brother was not unduly fat, but like him had six fingers and toes. He had a host of cousins all alive and well. None were obese nor did any of them have polydactyly. His father and mother were first cousins.

On examination: The patient was very obese. Fat was evenly and symmetrically distributed showing a predeliction to accumulate in the breast region, over the abdomen and buttocks. The face was round and features were symmetrical. The fingers were tapering and short. The legs and forearm were thin. He had six digits in both arms and legs. The extra digits were well developed.

He was not anæmic and had no Xerophthalmia. The *gait* was apparently normal though the buttocks swayed a bit. The *voice* was high pitched.

Cardiovascular system: Normal.

Respiratory system: Normal.

Abdomen: Distended with fat. No lumps felt. No shifting dullness. Liver and Spleen not palpable.

Nervous system: The patient answered questions intelligently and showed no signs of mental backwardness.

Cranial nerves: Normal.

Superficial, Deep and Visceral Reflexes: Normal.

Motor and Sensory Systems: Normal.

Pupils: Slightly dilated both eyes. React well to light and accommodation.

Genitalia: Were poorly developed. Both testes had descended into the scrotum. But their sizes were small. The penis was subnormal in size.

Fundus: Showed Retinits Pigmentosa both eyes.

Investigations: Urine: Reaction — Acid.
Specific gravity — 1015.
Albumin — Nil
Sugar — Nil.
Microscopic examination } Nil particular.

Blood: Total R. B. C. 4·2 millions per c. mm.
Hæmoglobin 12 Gms. %
Total W. B. C. 5600 per c. mm.
Differential count:
Polymorphs — 69%
Lymphocytes — 26%
Eosinophils — 4%
Basophils — 1%
Erythrocyte Sedimentation Rate (Westergren)
One hour — 4 mm.

Basal Metbolic Rate (as calculated by Read's Formula) (4).

Glucose Tolerence Test: Normal.

X-rays: The Sella Turcica was normal in size and shape. The pictures of his supernumerary fingers showed that he had 2 metacarpals and 2 metatarsals in them.

Family history: The parents are usually normal and healthy. It was so in this case. The patient was born after a full term normal delivery. At birth they are usually big. No birth weight of this boy could be obtained, but the mother stated that he was a big baby, and though the delivery was normal, she felt that during pregnancy, this boy, unlike the others was unusually heavy. With the next child she did not have any unusual feeling of weight and that child was and is normal in size, though it has six digits in both hands and legs.

This syndrome is considered to be a congenital familial condition affecting several members of the same family.

The patient is one of the four brothers. His two elder brothers are well and normal. The patient shows all the features of the syndrome. His younger brother exhibits only the presence of six fingers and toes.

The patient has cousins. None exhibit any of these features. Close questioning did not reveal the presence of any undue adiposity or polydactyly in the members of his parents and grand parents. Of the host of his relations, only he shows the syndrome in full and his brother probably in part. It is evident that only his branch of the family is affected And this is probably because his parents are involved in a consanguinous marriage. His mother and father were first cousins.

Consanguinous marriages are said to be one of the factors that bring to light a trait that otherwise remains latent. In this family, only in his branch where there is consanguinity the syndrome appears. The rest of his relations are unaffected.

Skin: In the Frolich's syndrome the skin is usually smooth due to atrophy of dermal connective tissues It is delicate hair free and it may show on the outer aspect of arms thighs and buttocks bluish red mottling.

This patient's skin was not extra smooth, and his complexion was ordinary. No mottling was also detected.

Legs and forearms: As compared to the thighs and upper arms the legs and forearms of this boy are not so adipose.

This feature is well marked in Frohlich's syndrome, where the legs and forearms are thin and graceful. The fingers are usually narrow delicate and tapering though occasionally they may be short. The fingers of this boy was of the latter description.

Genitalia: In Frohlich's Syndrome the genitalia are poorly developed so also the secondary sexual characteristics. The penis is small, the testes minute and quite often have not descended. They have little or no hair over the axilla or pubis. If pubic hair is present, it shows feminine distribution being limited horizontally and not extending upwards to the umbilicus.

Older boys and men have a feminine appearance and have only a sparse growth of hair or none at all, on their faces.

The case described, had small testes though both had descended. The penis was very small.

Voice: This boy had a high pitched unbroken voice. This is an usual feature in the Frohlich's Syndrome.

Mental and emotional changes: These patients are said to have a coloured personality. Periods of depression alternate with joyousness, high spirits and euphoria. They are usually lazy, good natured, amiable, excellent company and very popular with their school fellows

This patient appeared normal, and did not display any particular high spirits or depression. His intelligence was probably below par, if passing examination is used as a measure.

This boy is stunted to a degree. Quantitative measurement of urine on three seperate occasions did not reveal a polyuria. His sugar tolerance was also normal.

This patient though he could see well in the day was completely visually incapacitated in the night. It was particularly exemplified the way he had to fumble to see his way, in the darkened X-Ray room, though outside the department his visual acuity was normal.

The field of vision of this patient was normal. Annular or ring shaped scotoma may develop in these patients. This is progressive so that it may result in a tube vision. The central vision may remain unimpaired for several years.

The patient stayed in Hospital for two months and was on 1 gr. of Thyroid tablets per day. He however showed no improvement in weight or size.

During this period, his younger brother, who was not on any treatment, showed also no change in his weight or size.

Prognosis: The syndrome is progressive. Especially so the Retinitis Pigmentosa. Tubular vision eventually develops and this might progressively narrow leading to complete loss of vision.

Treatment: There is no adequate treatment for this condition. But the following may be tried.

1. Gonodotropic Hormone. This is given twice weekly for six weeks or more. It tends to produce sexual maturation, but does not influence the adiposity.
2. Thyroid tablets combined with restricted diet may influence the adiposity. This boy had 1 gr. of Thyroid daily for two months. It did not however influence his weight or size.

VIII. DISEASES OF BONE AND JOINT

D. M. O's. Unit.

1. A Case of Bifid Rib— Presented on 11—7—1953. By DR. D. LAKSHMANAN, M. B., B. S.

Name and etc.: Sheshagiri, 21 years, Hindu, Podanur.

Date of admission: 24—6—1953.

Previous illness or injury: No history of injury.

History of present illness: History of swelling over the median end of 4th rib medial to the nipple—Rt. chest, in the 12th year, lasting for a month. Again 15th year swelling only, no pain. Again 19th year swelling and pain lasting for the past 8 months.

Condition on admission: Swelling over the 4th rib just lateral sterno-costal junction. Tender. Not movable.

Pathological report 25—6—1953, TLC. 11,800/cm. m.

ESR. 1 hr. 2 m. m.

DLC. P. 37%.
L. 47%
E. 14%.
M. 2%.

Motion: No ova or cyst.

X-Ray Chest: 26—4—1953: Chondroma 4th rib Rt.

1—7—1953: Operation—Resection of rib by Dr. S. Balasubramaniam. Under general anæsthesia, 4th rib was exposed through transverse incision along the rib. Exposure done by cutting the pectoralis major muscle. The 4th rib is found fused with the 3rd rib anteriorly and is bifid. No tumour of the rib was seen. No evidence of inflammation over or under the rib. The bifid rib was resected for 4", right to the sternal margin. Wound closed in layers with drainage.

In the post-operative period the patient had some fever with nausea and vomiting.

The X-Ray revealed Hydro-pneumothorax on the Right side. Treatment with penicillin and sulphadiazine cleared up the condition. Discharged cured on 21—10—1953.

Comments: This is a case of a bifid rib rather an uncommon anomaly mistaken by the Radiologist for a chondroma. Even prior to operation the diagnosis of Bifid Rib was suggested; that it should have caused symptoms for a period of 10 years or so repeatedly necessitating the patient seeking surgical aid is not easily explained. The naked eye appearance of resected rib did not show any signs of gross disease. The hydropneumothorax is apparently the result of injury to the pleura at the time of operation though it was immediately sutured.

2. A Case of Solitary Plasmocytoma — By Dr. V. S. Kesavan, B.Sc., M.B., B.S.

Name and etc.· Ananda Bai, female, Hindu, Pupil Midwife.

Duration: 15 days.

History· Pain and swelling of lower half of left thigh 15 days duration. No history of injury—insidious onset with gradual increase in size of swelling, limping due to the slight pain over the swelling on bending and extending the knee. No fever.

General condition. Adolescent girl aged 17 years—not anæmic, well nourished. Abdomen, Heart and Lungs. nil abnormal.

Local condition: Fusiform swelling of lower half of left thigh. Swelling hard and bony; warm and slightly tender. No egg shell-crackling. Left knee joint free though movements produced pain over the swelling. Patient was found to be having low irregular temperature after admission.

Following investigations done:

Urine No albumin. No sugar.

Total Leucocyte count—12,000/cmm.

Diff. Leucocyte count: Poly. 63%, Lympho. 31%. Eosinophils 6%.

Blood Kahn—negative.

Blood sedimentation rate—36 mm. 1st hour.

Total R B. C. count—4·3 million/cmm.

Hæmoglobin %—80. Sahli's.

X-Ray left femur (No. 2248/11—5—1953) Areas of rarefaction with sub-periosteal new bone formation, lower third of Femur left. Reported as? Chronic Osteomyelitis lower third Femur left.

In view of the X-ray report, fever, leucocytosis, patient was put on chemotherapy and penicillin injections for about 25 days.

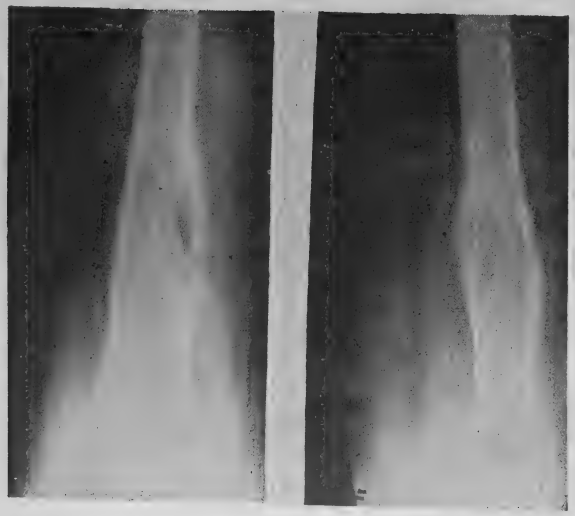
Patient did not show improvement at all.

A second X-ray taken (No. 2977/18—6—1953) revealed a marked difference from the first—Destruction of shaft for about 3½" lower third of shaft of femur involving both cortex and medulla.

This change has happened within a short interval of 35 days. Clinically the appearance is practically the same except slight increase in size. The diagnosis now suggested itself was? Osteolytic type of osteogenic sarcoma.

So biopsy was decided upon and on 26—6—1953, linear incision over lateral aspect of lower half of left thigh; Faschia lata and muscles split apart, and tumour mass approached, there was no bony tissue over the affected part of the femur—contained only jelly like material The jelly like material was removed Pathological fracture resulted during operation. Skin closed in layers and limb was immobilised in plaster spica. A bony bit and the jelly was sent for pathological examination The biopsy report (No. 3085 dated 8—7—1953) stated that the sections made from soft tissue suggest the tumour as plasmocytoma.

X-Ray Pictures of the Case of Solitary Plasmocytoma — by Dr. V. S. Kesavan



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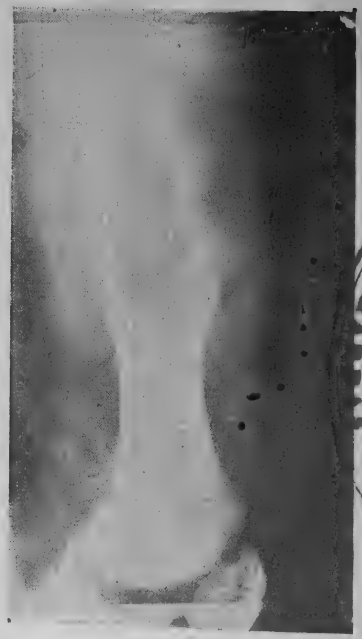
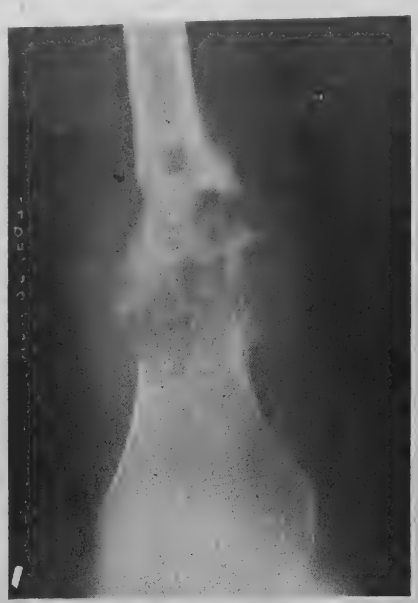


II

X-Ray Pictures of the Case of Solitary Plasmocytoma — by Dr. V. S. Kesavan

III



IV

V

X-ray skull, chest, pelvis etc. taken with result, that no other bone was found involved.

Urine for Bence Jones Protein repeatedly tested with negative result.

The X-ray appearances of the swelling taken from time to time are given below

1st picture: (No. 2248 dated 11—5—1953) Destruction for a length of 2" over the lower third of femur with subperiosteal new bone formation; cortex over the medial aspect is destroyed.

2nd picture: (No. 2977 dated 26—6—53) Destruction of bone is more advanced and included both cortex and medulla. Area of disease seems definitely demarcated from the rest of bone

3rd picture: (No. 3887 dated 8—8—53) Appearance — after local removal of tumour mass — Pathological fracture in the involved area. No further spread of disease.

4th picture: (No. 5977 dated 25—11—53) There is a well-marked attempt at regeneration of bone particularly from the upper and restoring somewhat the continuity. No further spread of disease.

Last picture (No 520 dated 26—1—54) A very marked change from the last X-ray. The entire bone in the area involved is more or less completely destroyed, leaving only an odd trabeculæ of bone here and there. The process has exceeded the confines of the bony frame work and spreading into the soft tissue. Still no spread of disease along the upper or lower fragments. X-rays of other bones taken at intervals have shown no change.

The tumour has been gradually becoming bigger month after month. It is nearly ten months now — has resulted in a huge fusiform swelling almost double the size of the thigh — very painful (often requiring morphia or pethidine injections) and tender, skin shining due to the stretch with superficial veins. Patient was tried with few intravenous injections of nitrogen mustard and few bottles of elixir urethane orally without any improvement. Patient's general health was terribly deteriorated — severe emaciation, raw tongue, continuous irregular temperature and occasional mild delirium, showing thereby the toxicity due to tumour. Fortunately for the patient, the agonising pain in the limb has disappeared since the last two months apparently because the tumour has exceeded the confines of the bone and is now spreading wildly into the soft tissue. Yet another blessing in this tragedy is that the patient is now altered mentally being childish and unaware of her fate.

Special Article

KERATOMALACIA

DR. D. SUNDARESWARAN, M.B., B.S., D.O.,
Honorary Assistant Medical Officer, Government Headquarters Hospital, Coimbatore

Keratomalacia or Vitamin A deficiency associated with softening of the cornea, as it is manifested in children and infants is such a common disease in our daily outpatients that a systematic study of more than fifty cases was made and a rough and ready method of tackling these cases has since been followed up in the Eye Department for a year and a few months.

Briefly the disease is due to a lack of Vitamin A in sufficient quantities in the system. It may be due to

(1) Reduced consumption of Vitamin A as from

(a) absence from diet

(b) defective absorption from intestines due to digestive troubles, i. e., cœaliac disease.

(2) Excessive utilisation as from

(a) Rapid growth

(b) Severe debilitating illnesses.

This Vitamin A otherwise called the Ophthalmic Vitamin is derived from carotene present in animal fat, milk, butter, eggs. Also present in large quantities in cod liver oil. The carotene is converted in the liver into Vitamin A.

The deficiency leads to structural changes in the respiratory, alimentary and urinary tracts and in the cornea, conjunctiva and lacrymal and tarsal glands, and therefore, keratomalacia is characterised by (1) hyperplasia and metaplasis of epithelium and mucous membranes. Columnar epithelium is changed into stratified epithelium and later on gets cornified. This change lowers the resistence to infection and so is accompanied by invasion of the area by micro-organisms and production of infective foci; (2) degenerative changes in medullated nerves both central and peripheral.

The disease may be from one of very mild symptoms to one of extreme debility, marasmus and death from pneumonia.

The disease is protean in its manifestations. One has to be on the look out for these cases if one is keen on diagnosing these cases early and treating them adequately. The progress of the disease in its advanced stages is so rapid that the cornea may soften in the course of a few hours with the end result of a pan total leucoma, staphyloma or ophthalmitis or death from pneumonia.

The following criteria were taken into account in studying these cases.

Cases associated with night blindness or smoky conjunctiva or nerosis or corneal ulceration and rapidly wasted body, diarrhœa or dysentery, bronchitis or bronchopnuemonia, loss of appetite, inability to digest foods, rapid loss of weight, œdema of the body and legs, were admitted and routine examination of

(1) urine for sugar and albumin

(2) motion for ova

(3) Hb %age

(4) total RBC count

carried out. These cases were attended to in the Eye Department daily with mercurochrome and cod liver oil; cod liver oil inunction to the abdomen and legs, administration of Vitamin A capsule 1 daily and 1 lakh Vitamin A injection intramuscularly daily for a period of ten days. Subsequently they were given all treatment except the injections of Vitamin A.

In the Baby Ward here these cases were admitted they had other treatment namely, (1) Penicillin 1 lakh units B. D. for cases of pyrexia (2) Bismuth and kaolin and sulphaguanidine tablets for cases of diarrhoea.

Treatment for worms was given for most of the cases, and malt extract with shark liver oil was also given orally, one teaspoonful twice daily.

This general regime of treatment was very effective in this series of cases as evidenced by the improvement in the lustre of the cornea and skin and many of these cases got alright excepting for a slight leucoma. Rarely a big leucome adherence necessitated an iridectomy operation later on.

The study of these revealed that in addition to Avitaminosis A, these cases were mostly (1) anæmic with an average of 70% Hb and 3·2 million RBC (in rare cases 2 million RBC). (2) Most of them had either round worm, whip worm or thread worm infection. (In Trinidad hook worm infection and in Egypt Cercariasis and Bilhaziasis are very commonly reported associated with Xerosis).

In selected cases without temperature Ultra Violet Ray exposures daily for 3 minutes for a period of three weeks were also given, the exposure being stopped when any cases developed temperature.

After the completion of 10 injections of Vitamin A, half a dozen injections of liver extract were also given to improve the blood. Cases that were discharged were given cod liver oil drops for the eyes and for inunction. They were also advised to give the children fresh cow's milk, one egg per day and tomatoes.

Mostly these children were the children of labourers and were second, third or fourth in their series Mostly both the parents were mill-workers and a history of an absence of enough breast milk was elicited. The economic condition of the patients is such that when these children go back to their old surroundings, they return again with the same symptoms.

Far from being able to solve the Socio-economic importance of the disease, the attempt is being continued of studying these cases, diagnosing them early, treating them adequately and returning them back to their homes.

The importance of examination of the eyes children suffering from diarrhœa, pneumonia, debility, marasmus for signs of Xerosis of the conjunctiva—smoky colour of the conjunctiva, corneal lustre and where possible by a Specialist with a view to urgent treatment cannot be over-emphasised. Any debilitating illness as an attack of small pox, measles, typhoid, pneumonia is prone to usher in the symptoms of this dreadful and crippling disease and the same sad tale has too often been repeated. The child recovers from the disease but becomes permanently partially or totally blind.

The Nutrition Institute at Coonoor suggests a dosage of 3 lakhs Vitamin A units intramuscularly daily once or sometimes twice for the 1st week or until symptoms have recovered While this high dosage may not be possible in an institution where the number of cases that come are increasing on account of economic conditions, I have been following the practice of giving 1 lakh units daily for 10 days even for outpatient cases and the dividends paid have been most gratifying.

The absorption of cod liver oil by the skin in children has been repeatedly favourably reported on by pædiatricians and exposure of the children to the sun in the evenings has also been beneficially commented on for the Ultra Violet Ray contents in the evening sun.

I feel that sometimes all out treatment is essential. Cases of diarrhœa have to be treated with bismuth, kaolin, sulphaguanidine and replacement of fluid lost by saline. Cases with temperature have to be treated with penicillin, i.m., and worms treatment to be repeated after a fortnight again. Many of these cases show brittle hair and nails, lustreless skin and papular eruptions called lichen pilaris and multiple furuncles are common. Voice also is husky due to affection of the mucous membrane of the larynx.

After the 10th year of life such cases are seen but gross changes are rarer Sometimes these cases are met with in epidemic form during the War when malnutrition, famine, fatigue and debility diseases were rife—in Brazil in the Negro slaves—in workhouses, in asylums, schools, prisons—after the great fast in Russia, when there is cessation of breast feeding and later improper dieting

Typically the mother comes to us saying that the child gropes about in the dark. Night blindness. This is presumably due to a functional deficiency of the visual purple In the earliest stages the sight is impaired when the intensity of illumination is lowered. Later on typical night blindness results.

Adequate supply of fresh cow's milk is essential as also eggs, fresh vegetables, butter. The cow's milk will contain enough Vitamin A only if the cow feeds on fresh green pasture, a factor which is sometimes forgotten.

Later on, the child develops lack of lustre in the skin and cornea; the conjunctivæ becomes dry and rolled up into folds particularly up the outer and inner angles in the form of a triangle called Biht's spots It has been aptly compared to the peelings of an onion.

The cases here show also a smoky colour of the conjunctiva, due to a sort of pigmentation which takes a very long time to disappear even after the child is adequately treated with Vitamin A.

Some cases come in with bronchitis and broncho-pneumonia. Some with diarrhœa, a few with indigestion and loss of appetite. Some come with an enlarged abdomen and our minds are engrossed on the liver and spleen. If in all these cases, the eyes are also examined carefully for signs of Vitamin A deficiency, we would be well and early on the way to treating these case successfully and saving a number of eyes.

In conclusion while this is largely a disease of the poor, it is met with in rich people also and in all these cases, the children have been weaned early either due to ill health of the mother or mostly due to ill-conceived motives. The new rich mother is not inclined to breast feed the children and tries to pass it on to somebody else (a wet nurse) or the rich artificial foods take their place as the mother is too busy with Social functions, engagements etc. The importance of feeding the new born children with breast milk cannot be over emphasised. It has been found that no article of food could replace the breast milk in its various contents of minerals, vitamins protective substances etc. Next to breast milk, ass's milk has been found to contain nearly the same proportion of ingredients. Cow's milk takes the next place only.

Special Article

HYDATIDIFORM MOLE (VESICULAR MOLE)

Dr. (Mrss) S. V. SWARNAM. M. B., B. S., D. G. O.
Hony. Asst. Medical Officer, Government Headquarters Hospital, Coimbatore

Vesicular Mole develops in the terminal branches of chorionic Villi. The embryo and its umbilical cord disappear when this degeneration spreads. The vesicles are transclucent and varying in size. These vesicles are covered by blood clots and fragments of decidua.

Histo-pathology: The essential feature of the vesicular mole is the proliferation of Langhan cells. The stroma of the villi is destroyed along with the blood vessels. The fluid in the vesicles cannot be explained and also how the vesicles are attached to the wall of the uterus. Even the simple vesicles erode the wall of the uterus. Thin walled cysts of the ovaries are always associated with the Hydatidiform mole and Chorion epithelioma. The cysts retrogress after the expulsion of the mole.

The books say the granulosa lutin cysts are found in 59% of Hydatidiform mole and 9% of Chorion epithelioma.

Incidence of Hydatidiform mole is 0 04% of all pregnancies (Shaw). More frequent in multipara (70%) than in primipara (30%). The age incidence is between 30 and 40.

The etiology is not definitely known. The modern view is that excess of anterior pituitory sex hormones is being circulated in maternal blood. The estimation of prolan content of urine in hydatidiform mole pregnancy corroborates this view. In all hydatidiform mole the Aschheim Zondek reaction of the urine is over 200,000 units per litre.

Diagnosis:- (1) Rapid increase in the size of the uterus.
(2) Irregular bleeding P. V.
(3) Symptoms of toxæmia.
(4) Absence of fœtal movements.
(5) Absence of fœtal parts (X-Ray).
(6) Positive Aschheim Zondek test.

Treatment: 50% of cases abort spontaneously. The rest have to be evacuated. The abdominal hysterectomy has its own advantage. The uterus can be evacuated entirely. If the mole has eroded into the uterine musculature a hysterectomy may performed.

One of the complications is persistent uterine hæmorrhage for weeks after the abortion. This may be due to (a) incomplete abortion, (b) endometritis, (c) Chorion epithelioma. A positive Aschheim Zondek test after two or three weeks the possibility of a Chorion epithelioma should be suspected because 14% of hydatidiform turn out to be Chorion epithelioma. A curettage of the endometrium is not useful in diagnosing a Chorion epithelioma if the Chorion epithelioma arises from the myometrium.

In Government Headquarters Hospital, Coimbatore in 1953 there were nine cases of vesicular mole out of 2880 cases of all pregnancies (giving a ratio of 1 : 320). Though the age incidence is said to be more between 30 and 40 we have had more in younger groups Of the 9 cases reported we have had one death. Three cases had subsequent hysterectomy for Chorion Epithelioma. The rest were evacuated and their recovery was uneventful.

Number of Vesicular Moles operated in 1953 in Government Headquarters Hospital, Coimbatore.

No.	Name	Age	Para	Admitted on	Discharged on	Remarks
1.	A	23	II	5—2—1953	11—2—1953	Evacuation ; (subsequent hysterectomy for Ch. Epithelioma).
2.	B	19	I	28—3—1953	3—4—1953	do. do.
3	C	27	V	3—4—1953	14—4—1953	Evacuation ; (subsequent hysterectomy for Ch. Epithelioma).
4.	D	22	III	12—4—1953	12—5—1953	Hysterectomy.
5.	E	28	VIII	17—4—1953	24—4—1953	Evacuation.
6.	F	18	III	28—4—1953	28—4—1953	do. (Expired)
7.	G	22	II	26—9—1953	12-10—1953	Evacuation.
8.	H	35	IX	10-11—1953	20-11—1953	do.
9.	I	28	IV	4-12—1953	15-12—1953	do.

Case Notes :

(1) No. 4 Mrs. D, 22 years, 3rd Para, married 7 years. Last child 18 months. Last period 22—1—1953. Admitted on 12—4—1953 for bleeding and vomiting. Duration 15 days

General condition : Fair. Heart and Lungs : Nil abnormal. Abdomen : Height of uterus 16 weeks size.

P. V. Os closed ; uterus 16 weeks, bleeding present. (Period of amenorrhœa is 3 months and height of uterus is more than 4 months size).

Diagnosis : Vesicular Mole.

18—4—1953 : The uterus is increasing in size rapidly. On and off there is bleeding. Height of uterus 28 weeks size.

21—4—1953. The vomiting is worse. Not able to retain food. Uterine hæmorrhage watery and pale in colour. Uterus acting slightly.

Treatment : 22—4—1954 : Under C2E3 cervix was dilated and vagina plugged. Injection pituitarine was given to induce labour.

28—4—1953 : Patient did not abort. Condition is deteriorating. Patient's vomiting is continuing. Transfusion was given. Blood Group 'O'.

Investigations : T. L. C. 13,000. D. L. C. P. 49% ; L. 34% ; E. 16% ; B. 1% B. P. 130/70. Hb% 70%.

1—5—1953. Operation: Abdominal Hysterectomy by Dr. S. Balasubramaniam. Considering the rapidly growing uterus over 28 weeks size and the highly toxæmic condition of the patient, hysterectomy was decided upon without delay. Under spinal anæsthesia, abdomen was opened. The uterus was very thin, bluish and soft. On opening the uterus the endometrium was found to be unhealthy The vesicles were very minute and covered with blood clots. There were bunches of Lutin cysts present.

The post-operative period was uneventful. Patient was discharged on 12—5—1953.

(2) No. 1 Mrs. A, 23 years, 2nd Para, married 6 years. Last child is 3½ years old. Last period 3 months back. Admitted on 5—2—1953 for bleeding off and on for the last one month. Patient complains severe vomiting and not able to retain any food.

General condition: Anæmia. Heart and Lungs: Nil abnormal. Abdomen: Height of uterus more than 14 weeks. Persistent intervals and intense toxæmic symptoms).

Treatment: Patient was treated for toxæmia.

11—2—1953: Patient had severe pain in the lower abdomen with profuse uterine hæmorrhage. The vesicles were expelled partially, so under anæsthesia the uterus was evacuated and curetted.

19—2—1953: Patient was discharged in a fit condition. On 26—3—1953 patient was readmitted for profuse uterine hæmorrhage. Condition on admission: patient was in a collapsed condition with rapid pulse and hurried breathing. Patient was very anæmic.

P. V. os open, uterus was filled with clots, a small mass was felt in the fundus of the uterus, firmly adherent.

Diagnosis: Adherent placenta? (Bleeding P. V. after 6 weeks and a palpable mass in the uterine cavity) Growth uterus? Chorion Epithelioma.

Treatment: 27—3—1953: Endometrial scrappings were sent for biopsy. (Result) Necrotic placental tissue.

Investigations: Hb .65% B. P. 130/70. Weight 90 lbs. X-Ray Chest Clear.

31—3—1953: Urine for Aschheim Zondek test was sent.

12—4—1954: Freedman's test was positive.

15—4—1953: Operation: Hysterectomy by Dr. S. Balasubramaniam. Under spinal anæsthesia. The cut section of the uterus revealed a small cauliflower-like growth in the fundus.

Biopsy report of the specimen was Chorion Epithelioma. Patient was discharged on 1—5—1953.

(3) No. 3. Mrs. C. 27 years, 5th para, admitted on 3—4—1953 with a history of four months amenorrhea, œdema legs and abdominal wall; dyspnœa and tachycardia. Hæmorrhage P. V. for 20 days.

General condition: Patient is very anæmic with rapid pulse. Heart sounds soft and rapid.

Abdomen: Height of uterus 28 weeks size. Fœtal heart not audible; fœtal movements not felt.

Investigations: Hb 55%. B. P. 160/100. X-Ray Chest clear; X-Ray abdomen: No fœtal parts.

Diagnosis: Vesicular mole with toxæmia and heart failure (period of amenorrhœa and height of uterus 28 weeks).

5—4—1953: Patient's condition was very poor. Uterus was increasing in size and bleeding P. V. Transfusion was given.

8—4—1953: Profuse uterine hæmorrhage. P. V. os admits tip of the finger, vagina plugged. Intravenous drip saline started.

9—4—1953: Patient was to be prepared for an abdominal hysterectomy but she started another bout of hæmorrhage; passed some vesicles. So under general anæsthesia the uterus was evacuated. I. V Plasmosan given. Patient improved but was discharged on 15—4—1953 against medical advice.

The same patient was readmitted on 22—6—1953 for continuous bleeding since the abortion. The patient complains of dyspnœa and weakness.

General condition of the patient was very anæmic Heart and Lungs nil abnormal. P. V. Uterus boggy and enlarged to a size of 12 weeks. Bilateral cystic swellings palpable in the fornices. Patient had a blood transfusion and and treatment with iron and liver.

Investigations: Hb. 70%—B. P. 100/65. Urine—nil abnormal. X-Ray lungs: Clear.

Diagnosis: Chorion Epithelioma.

13—7—1953: Operation—Hystero-salpingo-oophhrectomy by Dr. S. Balasubramaniam.

Under spinal anæsthesia.

Biopsy report of the specimen: Chorion Epithelioma. On 29—7—1953 the patient was discharged cured.

THIRD ANNUAL REPORT

OF THE

CLINICAL ASSOCIATION OF GOVERNMENT HEADQUARTERS HOSPITAL,

COIMBATORE.

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President, Ladies and Gentlemen,

It is with great pleasure and satisfaction that I place before you the THIRD ANNUAL REPORT of the CLINICAL ASSOCIATION of Government Headquarters Hospital, Coimbatore.

It was one year ago during the last week of January that we celebrated the second Annual Meeting under the Presidentship of Dr. S. Balasubramaniam, M. B., M. S., District Medical Officer. The President in his Opening Speech expressed his deep appreciation for all the kindness and co-operation extended to him by the members and requested them to give their active help and fruitful collaboration during the year.

All Doctors attached to the hospital are members of the Association. During the first year there were 35 members, 2nd year 36 and now we are 40 strong. As usual we are still encouraging and welcoming other members of the profession to attend the meetings and many are attending the meetings regularly.

Meetings: We can take legitimate pride in having conducted 24 meetings during the year as we resolved three years ago. An extraordinary meeting of the Clinical Association was held on 21st February 1953 at 9 a. m. to meet Dr. Erik Husfeldt, Professor of Thoracic Surgery, University of Copenhagen and Dr. Stuart C. Cullen, Professor of Anæsthesiology, the State University of Iowa, Members of the Visiting Team of Medical Scientists sponsored by the World Health Organisation The distinguished visitors were introduced to the members by the President. They appreciated the activities of the Association and thanked the President and the members for having given them an opportunity to see the working of a District Headquarters Hospital. The 51st meeting of the Association was marked by the visit of the Honourable Minister of Health, Government of Madras. The President first introduced the members to the distinguished Visitor and explained to him the aims and activities of the Association and requested the Minister to speak a few words to the members. The Honourable Minister informally addressed the meeting In his address, he stressed the importance of training the young graduates in Medicine and Surgery in the bigger hospitals to enable them to do good quality of work in the taluk headquarters stations. At the request of the President, the Honourable Minister awarded the Prize endowed by Dr. P. K. Kalyanaraman, Honorary Physician for the best medical case presented during 1951 to Dr. Jayakumar. There was an exhibition of a Medical film "Antihistamine Agents" by the courtesy of Messrs. May & Baker Ltd , Madras on 8—8—1953 which was very much appreciated by the members

Cases: A variety of interesting clinical cases was presented during the meetings. During the year as many as 147 cases of which 63 Medical, 62 Surgical, 18 Ophthalmic and 4 E. N. T. were presented, discussed and views exchanged. On an average 6 cases were demonstrated at a meeting.

Souvenir: A Souvenir of 1952 as intended was published which contained 31 case reports, 3 special articles, a review of the treatment of cholera cases in the Headquarters Hospital during an epidemic in the year, besides the President's Opening Speech and the Secretary's Annual Report. A new feature of this issue was the 'Hospital Notes' detailing the notable events of the year. The high standard and excellent get-up of the Souvenir which showed a definite all round improvement was appreciated by all.

Conclusion: I am sure you all will agree with me when I say that we are fully justified in congratulating ourselves for having conducted 72 meetings during the last three years, keeping up to the very letter and spirit of the resolution we took in the Inaugural Meeting. It is very seldom given to any Association to be so unique in its achievements. This has been made possible by the hearty co-operation of all the members and the abiding interest taken by our President. It is in the fitness of things, therefore, that I thank you all, for having made this Association of ours a great success.

Jai Hind!

Govt. Headquarters Hospital, Coimbatore,
24—1—1954.

C. T. Simon, ***B.A., M.B., B.S.,***
Hon. Secretary,
Clinical Association.

HOSPITAL NOTES

Buildings:

A large number of sick destitutes were being brought to the Hospital for admission. This posed a difficult problem as the Hospital was already overcrowded. The Superintendent requested the Municipality to look after these destitutes themselves by putting up a ward in any of their dispensaries or if they cannot do so to build a semi-permanent ward in the Headquarters Hospital compound. Such a ward of 20 beds with sanitary fittings etc. has been constructed at a cost of about Rs. 5,000/- This ward goes some way to ease the problem of accommodation in this hospital.

Proposals for the construction of additional consulting rooms in the Outpatients are approved.

Construction of an additional room near the Operation Theatre Block to be used for minor surgery, plastering etc. is about to commence.

Enlarging the Theatre in the Ophthalmic Department is sanctioned and awaiting execution.

Refresher Course for Doctors:

A Refresher Course for Doctors in Governmant service as well as private practitioners was held in the Hospital from 5—10—1953 to 14—10—1953 as per Scheme in G. O. Ms No. 1463 H dated 17—4—1953. In addition to the 20 doctors specially selected for the Course, a very large number of doctors from the town and mufassal attended these lectures and demonstrations. The average attendance at these lectures was as high as 70. The Refresher Course was considered quite a success

Republic Day:

The Annual Republic Day was celebrated in a grand manner. On 26—1—1953, with an aim to provide sport and pastime to all categories of staff of the hospital particularly the low-paid, sports consiting of over 20 events was held in the afternoon. Many of the items were earmarked for the lower paid staff, just two being allotted to doctors and nurses. Tea and light refreshments were provided for the entire staff and children during the interval at 4-30 P. M. Useful and handy presents of household articles of a value of about Rs. 500/- were distributed to the winners at the close of the day. The entire staff co-operated and collaborated to make the function a success.

Hospital Day — Red Cross Week:

The Hospital Day was celebrated on 14 and 15—11—1953 during the Red Cross Week A Medical Exhibition was conducted in the A. T. Devaraja Mudaliar Tuberculosis Clinic Building and the adjacent ground where a number of tents was put up. In the exhibition were sections dealing with Blood Bank, Maternity, Surgical and Orthopædic Instruments, Iron Lung, Laboratory exhibits and public health poster exhibits etc. A special section on Family Planning with diagrams and samples of appliances was a new feature. Besides these, examination of different kinds as weight and blood pressure, eye, blood, urine, X-Ray, complete check-up etc. were all offered at nominal cost. The collections were Rs. 1,064—8—3 which exceeded the last year's by over Rs. 600/-. The event was a great success in getting the public associated in a popular manner with the work turned out in this Hospital.

General:

On the abolition of the Regional Committee for Selection of Nurse Pupils at Kozhikode, Government ordered the constitution of a similar Committee at Coimbatore for the selection of Nurse Pupils. During this year, the Committee met twice in the Government Headquarters Hospital, Coimbatore in June and December 1953.

On the proposal of the Superintendent, the Red Cross Society of Coimbatore Branch employed a Health Visitor for working in the Tuberculosis Clinic in the forenoons and doing out-door propaganda and contact work in the afternoons.

The Red Cross was also helping the Hospital, by giving about Rs. 1,200/- worth of anti-tuberculosis drugs for treatment of poor out-patients.

The Superintendent addressed a meeting of the local Rotary when he suggested that they may help the hospital in many ways. Thereupon on the request of the Superintendent the Rotary donated a Surgical Diathermy apparatus to the Hospital at a cost of Rs. 2,600/-. This is found to be a very valuable addition to the Theatre equipment.

The suggestion of the District Medical Officer, Coimbatore at the IV District Medical Officers' Conference held at Madras in August 1952 to collect an anna each from well-to-do patients attending the Out-patient Departments was approved by the Government and given a trial at this hospital in the first instance, from 1—6—1953. This was extended to the in-patients also a month later. No compulsion of any sort was made in the levy. The collections in the year since its inception amounts to over Rs. 3,385/-

It is proposed to conduct Rural Medical Service with the voluntary help of the staff of the hospital. The Red Cross Medical Van specially remodelled for the purpose is put into use. The villages chosen are Chavadi and Chinnathadagam in Coimbatore Taluk.

Staff:

During the year two more posts of Honorary Assistant Medical Officers — one Orthopædic and one Radiology — were created and filled up.

Statistics:

		1952	1953
In-patients:			
Total treated	...	24,599	25,306
Daily average	...	754	763
Out-patients:			
Total treated	...	1,86,472	1,90,451
Daily average	...	1,063	1,233
Operations:			
Major	...	2,206	2,089
Minor	...	8,558	11,665
Deliveries:		3,927	2,432*

* Fall on account of the opening of a Women and Children Hospital at Coimbatore in June 1952 which continued to function fully in 1953.

APPENDIX

LIST OF MEETINGS HELD IN 1953

48th Meeting on 10—1—1953

1. **Atelectasis** by Dr. K. V. Ranganatham
2. **Dislocation Shoulder — 2½ months duration**
3. **Glands Neck** — both cases by Dr. V. K. Rajagopalaswamy
4. **Fracture Olecranon** by Dr. Rajuvedan
5. **Tumour Abdomen — 2 cases for diagnosis** by Dr. (Mrs.) Anna Vareed

49th Meeting on 24—1—1953.

*6. **Intussusception in a child** by Dr. S. Balasubramaniam
7. **Ataxia**
8. **Paroxysmal Dyspnœa** both by Dr. Jayakumar
9. **Pain Chest Right** by Dr. K. V. Ranganathan
10. **Melanoma Rectum** by Dr. P. K. R. Warrier
11. **Monteggia Fracture** by Dr. E. Rajuvedan

50th Meeting on 14—2—1953

12. **Glioma, both eyes** by Dr. D. Sundareswaran
13. **Tabes Dorsalis**
14. **Quadriplegia** both by Dr. N. Subrahmanyan
15. **A Case of Mediastinal Tumour** by Dr. Jayakumar
16. **A Case of Vascular Disease**
17. **A Case of Secondaries in the Lungs** both by Dr. Sriramulu

51st Meeting on 28—2—1953

*18. **Mediastinal Syndrome**
19. **Hydro-pneumo-pericardium** both by Dr. Jayakumar
20. **Bronchogenic Carcinoma**
*21. **Polyneuritis** both by Dr. N. Subrahmanyam
22. **Dentigerous cyst — Maxillary Antrum** by Dr. S. Balakrishnan
23. **Circoid Aneurysm**
24. **Growth Lower End Radius** both by Dr. C. N. Santhanam
25. **Bilateral Inguinal Hernia** by Dr. P. K. R. Warrier
26. **Epithelioma Limbus** by Dr. D. Sundareswaran
27. **Smith Peterson's Fracture Neck of Femur** (X-Rays) by Dr. C. N. Santhanam

52nd Meeting on 14—3—1953

28. **Hydronephrosis** by Dr. P. K. R. Warrier
29. **A Case of Hypo-thyroid State**
30. **Subacute Bacterial Endocarditis** both by Dr. N. Subrahmanyan
*31. **Tumour Mesentery** by Dr. (Miss) S. V. Swarnam

53rd Meeting on 28—3—1953

32. **T. B. Mastoiditis with Facial Palsy and Sinus Thrombosis**
33. **Papilloma Vocal Chord** — 2 Cases
34. **T. B. Both Bronchi** all by Dr. S. Balakrishnan
35. **Pseudo-muscular Hypertrophy** by Dr. S. Ganapathi
36. **Mediastinal Tumour** by Dr. N. Subrahmanyan
37. **Tumour Abdomen** by Dr. P. K. Kalyanaraman

54th Meeting on 11—4—1953:

38. **Atypical Virus Pneumonia**
39. **Ruptured Aortic Aneurysm**
40. **Cerebral and Cardiovascular Syphilis** — all by Dr. Jayakumar
*41. **Obstructed Incisional Hernia — Specimen** shown by Dr. S. Balasubramaniam
42. **Keratomalacia** by Dr. Sundareswaran
43. **A Case of Abscess Right Upper Zone** (treated with streptomycin in November 1952) **developing Hypothyrodism** by Dr. P. K. Kalyanaraman

55th Meeting on 25—4—1953.

44. **Ophthalmoplegia** by Dr. D. Sundareswaran
45. **2 cases of V. D. H.** by Dr. Jayakumar
46. **Aortic Stenosis with Regurgitation** by Dr. N. Subrahmanyan
47. **A Case of Prostatectomy** by Dr. M. P. Pai
48. **Sarcoma Face** by Dr. A. G. Leelakrishnan
49. **Syndactilism** by Dr. E. Rajuvedan
50. **An Unusual Case of Dwarfism** by Dr. N. Vanchinathan

56th Meeting on 9—5—1953.

51. **Hare Lip — Modern Method of Repair** by Dr. M. P. Pai
52. **Hæmaturia**
53. **Headache — A Case for Discussion** both by Dr. N. Subrahmanyan
54. **A Case of Scoliosis** by Dr. Rajuvedan

57th Meeting on 23—5—1953.

55. **Membranous Conjunctivitis**
56. **Byophthalmos Unilateral** both by Dr. D. Sundareswaran
57. **2 Cases of Pituitary Disease**
58. **Muscular Dystrophy** both by Dr. Jayakumar
59. **Subphrenic Abscess** by Dr. E. Rajuvedan
60. **Gastric Ulcer — Specimen** by Dr. A. G. Leelakrishnan
61. **A Case of Ataxia** by Dr. N. Subrahmanyan

58th Meeting on 13—6—1953:

62. **Cavernous Sinus Thrombosis Left Eye**
63. **Partial Opthalmoplegia** both by Dr. D. Sundareswaran
64. **Chondroma Hand** by Dr. C. N. Santhanam
65. **Melanoma Foot** by Dr. Sriramulu
66. **Tumour Neck**
67. **Injuries Around Elbow Joint** both by Dr. E. Rajuvedan

59th Meeting on 27—6—1953.

*68. **Gall Stones** by Dr. (Mrs.) Anna Vareed
*69. **Three Cases of Hydro-nephrosis** by Dr. E. Rajuvedan
*70. **A Case of Tumour Kidney** by Dr. (Miss) S. V. Swarnam
71. **Retropharyngeal Diverticulum** by Dr. S. Balakrishnan
72. **Gumma Eyelid** by Dr. D. Sundareswaran
73. **A Case of Recurrent Attacks of Jaundice** by Dr. N. Subrahmanyan
74. **Tumour Thyroid** by Dr. Sriramulu
75. **A Case of Exostosis** by Dr. C. N. Santhanam
76. **A Case of Anterior Colporhexy** by Dr. (Miss) A. Ranganayaki

60th Meeting on 11—7—1953:

*77. **T. B. Cæcum** (From D. M. O.'s Unit) by Dr. (Miss) S. V. Swarnam
*78. **Bifid Rib** by Dr. D. Lakshmanan
79. **Osteogenic Sarcoma Femur**
80. **Caries Rib** both by Dr. V. S. Kesavan
81. **A Case of Pericardian Effusion** by Dr. N. Subrahmanyan
82. **Aphasia**
83. **Atiral Septal Defect** both by Dr. Jayakumar
84. **Recurrent Meningitis** by Dr. K. V. Ranganathan

61st Meeting on 25—7—1953

85. **Congenital Disease of the Heart** by Dr. Jayakumar
86. **Congenital Abnormality of the External Genitalia in a fœtus** by Dr. C. N. Santhanam
87. **Keratitis — 2 cases**
88. **Injury — L. D. Repair** both by Dr. D. Sundareswaran

62nd Meeting on 8—8—1953:

89. **Lawrence-Beadle-Moon Syndrome** by Dr. D. Lakshmanan
90. **Blindness Complicating pregnancy** by Dr. (Miss) S. V. Swarnam
91. **Retinopathy** by Dr. N. Subrahmanyan

63rd Meeting on 22—8—1953

*92. **A Case of Splenic Swelling** by Dr. D. Lakshmanan
93. **2 cases of Nephritis** by Dr. Subrahmanyan
94. **Tumour Ileum — Osteogenic Sarcoma**
95. **Multiple Subcutaneous Swellings** both by Dr. C. N. Santhanam

64th Meeting on 19—9—1953

96. **Bilateral Embolism of the Central Artery of the Retina** by Dr. D. Sundareswaran
97. **Congenital Heart Disease** by Dr. Mohamad Ali
98. **Scalenus Anterior Syndrome — Cervical Rib** by Dr. Sriramulu
99. **Anomalous Peritoneal Encapsulation of the small intestine** by Dr. D. Lakshmanan
100. **Sub Arachnoid Hæmorrhage** by Dr. N. Subrahmanyan
101. **Demonstration of a Grade Six Systolic Murmur** by Dr. Jayakumar
102. **A Case of Exomphalos** by Dr. C. N. Santhanam

65th Meeting on 26—9—1953

103. **Ossium Fragillitas** by Dr. C. N. Santhanam
104 **Malignant Gastric Ulcer** by Dr K. M. Venkatachalam
105. **2 Cases of Anæmia** by Dr. Jayakumar
106. **Sub Arachnoid Hæmorrhage** by Dr. K. V. Ranganathan
107. **A Case of Arthritis Knee** by Dr. K. M. Venkatachalam
*108. **A Case of Chronic Intussusception** by Dr. Lakshmanan
109. **2 Cases of Congenital Heart** by Dr. P. K. Kalyanaramnan
110. **Case of Ruptured Aneurism** by Dr. (Mrs.) Anna Vareed
*111. **Tuberculosis of the Kidney** by Dr. V. S. Kesavan

66th Meeting on 17—10—1953:

112. **Carcinoma Eye Lid** by Dr. D. Sundareswaran
113. **Lymphangioma** by Dr. K. M. Venkatachalam
114. **Bilateral Facial Palsy**
115. **A Case of Congenital Heart Disease**
116. **Polycystic Kidney**
117. **A Case of Cerebral Syphilis**
118. **A Case of Polycystic Lung** all by Dr. N. Subrahmanyam

67th Meeting on 31—10—1953 :

119. **Optic Neuritis** by Dr. D. Sundareswaran
120. **Tumour Kidney — Malignant** by Dr. C. N. Santhanam
*121. **Vesical Calculus** by Dr. C. T. Simon
122. **Traumatic Pericardial Effusion** by Dr. Mohd. Ali
123. **Bilateral Facial Palsy** by Dr. Jayakumar
124. **Aneurysm of the Ascending Part of the Aorta** by Dr. Sriramulu
125. **A Case of Gastric Ulcer on the Lesser Curvature** Specimen Shown by Dr. V. S. Kesavan

68th Meeting on 21—11—1953

126. **A Case of Endophthalmitis** by Dr. D. Sundareswaran
127. **Placcid Quadriplegia** by Dr. K. V. Ranganathan
128. **Phlegmasia Alba Dolens** by Dr. S. Rajarathnam
129. **Fracture Dislocation Both Shoulders** by C. V. David
130. **A Case of Gastrectomy for Gastro-jejunal Ulcer** by Dr. C. N. Santhanam
*131. **A Case of Tubo-ovarian Mass with a fœtus inside** by Dr. (Mrs) K. G. Janaki Bai
132. **A Case of Gastro-Duoderectomy — Specimen of Stomach and Duodenum shown** by Dr. (Miss) S. V. Swarnam

69th Meeting on 28—11—1953

133. **A Case of ? Increased Intra Cranial Pressure** by Dr. D. Sundareswaran
134. **Atrial Septal Defect** by Dr. Jayakumar
135. **Lupus Erythmatosis** by Dr. Chandrasekharan
136. **Extensive Lupus of Nape of Neck** by Dr. Venugopalakrishnan
137. **Treacherous Appendix** by Dr. M P. Pai
*138. **A Case of Obstructed Hernia** by Dr D. Lakshmanan

70th Meeting on 12—12—1953

139. **Retro-bulbar Neuritis — Skiagrams** by Dr. D. Sundareswaran
140. **Tubercular Meningitis** by Dr. M. N. Menon
141. **Meckel's Diverticulum** by Dr. C. N. Santhanam
142. **Bronchiectasis** by Dr. N. Subrahmanyan
*143. **2 Cases of Hydronephrosis**
144. **A Case of Volkman's Contracture** both by Dr. D. Lakshmanan
*145. **Full term Abdominal Pregnancy** by Dr. Mrs. Anna Vareed

71st Meeting on 26—12—1953

146 **A Case of Meningioma** Dr. Kalyanaraman's Unit by Dr Jayakumar
147. **A Case of Nystagmus**
148. **A Case of Mediastinal Syndrome** both from Dr. Menon's Unit by Dr. N. Subrahmanyan
*149. **A Case of Hydatid Cyst** — D. M. O.'s Unit by Dr. (Miss) S. V. Swarnam
150 **Pain, left shoulder and Hæmoptysis** by Dr. Sriramulu

Note Cases marked with asterisk (*) above find publication in the Souvenir.

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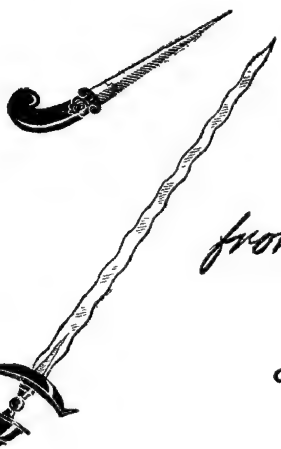

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Honorary Assistant Medical Officer, Tuberculosis Department.

11 ,, S. Balakrishnan, M. B., B. S., D. L. O.,
Honorary Assistant Medical Officer, E. N. T. Department.

12 ,, N. Subrahmanyan, M. B., B. S.,
Honorary Assistant Medical Officer, Medical.

13 ,, P. P. Balakrishnan, M. B., B. S., D. O.,
Honorary Assistant Medical Officer, Eye Department.

14 ,, A. G. Leelakrishnan, M. B., B. S.,
Honorary Assistant Medical Officer, Surgical.

15 ,, (Miss) K. M. Jalajam, M. B., B. S.,
Honorary Assistant Medical Officer, General.

16 ,, C. N. Santhanam, M. B., B. S.,
Honorary Assistant Medical Officer, Surgical.

17 ,, S. Ganapathi, M. B., B. S., *Honorary Assistant Medical Officer, General.*

18 ,, S. G. Rajarathnam, M. B., B. S.,
Honorary Assistant Medical Officer, General.

19 ,, K. V. Ranganathan, B. Sc., M. B., B. S.,
Honorary Assistant Medical Officer, Medical.

20 ,, V. S. Kesavan, B. Sc., M. B., B. S.,
Honorary Assistant Medical Officer, Surgical.

21 ,, K. Thiruchitrambalam, M B., B. S.,
Honorary Assistant Medical Officer, General.

22 ,, R. Lakshmana Rao, L. M. P., *Honorary Assistant Medical Officer, X-Ray.*

23 ,, K. R. Venkatesalu, M. B , B. S ,
Honorary Assistant Medical Officer, Orthopaedic.

House Surgeons:

1 Dr. R. A. Rahman, M. B., B. S., *House Surgeon (Paid).*

2 ,, V. M. Shanmughasundaram, M. B., B. S., *House Surgeon (Paid).*

3 ,, N. Venugopalakrishnan, M. B., B S., *House Surgeon (Unpaid).*

4 ,, V. Sri Ramulu, B. Sc., M. B., B. S., *House Surgeon (Unpaid).*

5 ,, R. G. Chandrasekharan, M. B., B S , *House Surgeon (Unpaid).*

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